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THE UNIVERSITY OF ALBERTA

SUICIDAL NO LONGER: A JOURNEY AWAY AND RETURN TO SELF

BY

MURIEL HOOVER ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY.

IN

COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL, 1994

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FACULTY OF GRADUATE STUDIES AND RESEARCH

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DEDICATION

In memory
Of those for whom
The invalidational abyss
Was crossed on death wings.

For those who struggle,
To fly again.
To be
Suicidal no longer.

ABSTRACT

Treatments dealing with suicidal behaviour vary according to how suicide is conceptualized. Research on suicide prevention, theory and therapy has been primarily from the theorist's or researcher's perspective. In this study once suicidal participants were interviewed and asked "What was helpful in suicidal healing?" Participants' stories of their process and healing were collected and thematically analyzed, adding to existing perspectives in suicide research. The metaphor of 'A Journey Away and Return to Self' describes the dynamics that emerged. A journey away from self describes the participants' suicidal processes as they disconnected from others and from the self: their feelings, self worth, and ability to negotiate their lives. The metaphor of a return to self describes their healing experiences as reconnection with others and the self through feeling, self awareness and honouring the self, breaking old patterns and establishing new ones. The new patterns were the antitheses of worthlessness, helplessness and hopelessness. Participants' descriptions in this phenomenological investigation provide an understanding of the healing process with implications for directing treatment and evolving an integrated rationale for therapeutic intervention with suicidal individuals.

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CHAPTER ONE

INTRODUCTION

Suicide and suicidal behaviour are problems for society and challenges for mental health professionals. Suicide has become the fifth leading cause of death in Canada (Health and Welfare Canada, 1987). Completed suicide, however, represents only a small percentage of suicidal behaviours. Rates are increasing for completed suicide (Dyck, Neuman & Thompson, 1988; Eastwood, 1980; Robins, 1985) and for attempted suicide as well (Jarvis, Ferrence, Johnson, & Whitehead, 1976; Shaffer, Garland, Gould, Fisher & Trautman, 1988).

Strategies dealing with suicidal behaviour vary; the type of treatment employed is dependent on how suicide and suicidal behaviour are conceptualized. The different models of suicide prevention, theory, therapy and research offer a variety of perspectives on conceptualizing and treating suicidal behaviour. Prevention and intervention strategies employed to reduce deaths and self injury are delivered from a number of different levels. Primary prevention seeks to intervene proactively with awareness and referral programs. The basic assumption is that accurate prediction and identification will lead to effective secondary and tertiary interventions averting deaths. This level of intervention is important considering that suicidal behaviour is often not detected (Coombs, Miller, Alarcon, Lee & Morrison, 1992). Typically, secondary and tertiary interventions are delivered through traditional treatment approaches. A variety of treatment interventions have been shown to be effective in treating suicidal behaviour. Overall, the confidence in the findings of outcome studies is challenged by methodological weakness and inconsistent results.

Confidence in identification and treatment is also challenged by the incidence of suicide deaths among those who have communicated their intent (Kovacs, Beck & Weissman, 1976; Robins, Gassner & Kayes, 1959; Stengel, 1964), sought help (Barraclough, Bunch & Nelson, 1974; Fawcett, Clark & Sheftner, 1991; Robins, Gassner & Kayes, 1959), and received treatment (Barraclough et al., 1974; Crammer, 1984; Greer & Bagley, 1971; Moss & Hamilton, 1956; Robins et al., 1959; Weissman, Fox & Klerman, 1973). These findings challenge the existing assessment and treatment efforts to reduce suicide and suicidal behaviour. It is important to be able to identify and treat those who are suicidal, and this requires expanded efforts in developing effective assessments and treatments.

This study represents an exploration of treatment by investigating what has been helpful in healing from suicidal behaviour. Rather than viewing suicide interventions from the perspective of conceptual models or single factor predictors, this study explored interventions from the perspective of the once suicidal individual. How interventions and healing were experienced by those who were once suicidal provides an enriched view of what is helpful in planning effective treatment interventions. Individuals' stories, their experiences and processes of healing, add another view to the existing perspectives of the theorist, therapist and observer.

The incidence of suicidal behaviours and the need for effective strategies to deal with these behaviours present a challenge to mental health professionals. As a therapist working with suicidal clients I experience this challenge and have sought direction from the expertise and experience of others. I have learned a great deal from published works, consultations with other therapists and my clients. I have also learned there is a great deal we do not know about healing and treating suicidal behaviours. It seems fitting to ask those who have made the journey into the suicidal abyss and out again, what was helpful for them. Beyond my professional interests, I have personally experienced the impact of suicide deaths. An initial query in that painful state was 'why', followed in time by 'what would have helped'? Both my professional and personal interests have prompted this inquiry.

In this introduction the point has been made of the prevalence of suicide and suicidal behaviour and the prevalence of those who die having communicated their intent and sought out and received treatment. I see this as an indicator of the need for further, and different, explorations of what is helpful in treating suicidal behaviour. What we have been doing isn't working well enough.

This dissertation explores what has been helpful in suicidal healing, first through a review of traditional treatments and then through what was helpful in healing from the perspective of the once suicidal who participated in this study. Chapter Two describes the patterns and incidence of suicide and suicidal behaviour, the terminology used to clarify and classify these behaviours and the traditional and theoretical approaches through which we have come to understand and treat suicidal behaviours. Chapter Three describes the method of phenomenology, chosen to study the process of healing from the once suicidal individuals' perspective. Chapter Four presents the results of the phenomenological interview analyses. A diagram(s) illustrates the overall thematic structure revealed through the interview descriptions of healing. This is followed by a detailed explication of each of the themes, with illustrative quotations from the participants' protocols. Chapter Five discusses the themes and their implications for suicidal healing, particularly as they are relevant in directing treatment.

CHAPTER TWO

LITERATURE REVIEW

Patterns and Incidence of Suicidal Behaviours

Throughout the 20th century, rates of suicide have been increasing in all industrialized countries (Eastwood, 1980; Robins, 1985). Albeit with fluctuations, Canadian rates have seen a steady increase, and U.S. rates have shown a slight decline since 1976 (Health and Welfare Canada, 1987). Suicide has become one of the leading causes of death, its position varying in the top ten according to specific patterns of age or sex. Overall, in the 1980s, suicide was the fifth highest cause of death in Canada (Health and Welfare Canada, 1987); and ninth in the U.S., ranking second as the cause of death among young adults (Dorwart & Chartock, 1990).

Completed Suicide: Age and Gender Patterns

Among the most consistent observations of completed and attempted suicide are the different rates by gender across the life span. Generally, suicide rates increase with age for both males and females, with males at all ages completing suicide more frequently than females at a ratio of 3:1. As they grow older females tend to complete more frequently, with their rates peaking at an earlier age than for males. Overall, female rates have been declining, in Canada and the U.S., since the early 1970s ((Dyck, Neuman & Thompson, 1988; Health and Welfare Canada, 1987; Maris, 1981; McIntosh and Jewell, 1986).

The long term trend of elderly suicide has been one of decline (Kreitman, 1979); but the short term trend is upward, with increases in suicide rates for those aged 55 + in Canada since 1976 (Dyck et al.,1988), and in the U.S. for those aged 65 + since 1981 (McIntosh, 1992). It has been suggested that any reduction in the overall rate of suicide in the U.S. is accounted for by the overall decline in the rates for elderly males. Notwithstnding the lower rates, men age 60 + have the highest suicide rate of any age group (Manton, Blazer, & Woodbury, 1987). The overall decline of rates for the elderly has been observed over a longer period, since the 1930s, than the increase in rates for the young, which began in both Canada and the U.S. in the 1950s (McIntosh, 1992).

The rates of suicide for youth have increased faster than the rates for any age group, with the rates for young adults, not adolescents, increasing the most (Dyck et al. 1988; Shaffer, Garland, Gould, Fisher, & Trautman, 1988). One group of youth at lower risk for suicide are college students, with rates at half their non student cohorts (Whitaker & Slimak, 1990).

Given that the 'baby boomer' cohort is aging, trends indicate that this group represents by its size and tendency towards suicide, relative to earlier cohorts, that rates will increase into the next century, escalating the current upward trend into a much larger, and longer upward trend.

Attempted Suicide: Age and Gender Patterns

Rates of completed suicide are officially recorded, but no such data is systematically kept for suicidal behaviours that do not result in death. Earlier estimates of attempted suicide were of 8 or 10 attempts to one completed suicide (Maris, 1981). Recent research on self injury has revealed this estimate to be extremely conservative. Rates and ratios vary considerably by age and sex, making overall figures misleading. Young females have been shown to have rates up to 600 and 800 per hundred thousand, with ratios of attempted to completed suicide up to 200 and 300:1. Young males' rates are up to 300 and 400 per hundred thousand, with ratios of attempt to completed suicide at 20 to 30:1 (Health and Welfare Canada, 1987; Jarvis, Ferrence, Johnson & Whitehead, 1976). Goldney and Burvill (1980) report increases in attempts, and Kessler and McRae (1983) report increases in attempts by males, particularly young males. Females attempt more frequently than males at all ages except for males age 65 + who attempt more frequently than females (Jarvis et al., 1976). The differences between the sexes, with particular relevance to attempts, is greater among the young and tends to decrease over time.

The patterns of sex and age differences of both attempted and completed suicide are quite distinct and dramatic. This data on the nature and level of suicidal behaviours informs us that men and women, the young, the elderly and those in between are each at risk according to their own specific pattern.

Impact of Suicidal Behaviours

As the actual numbers of persons engaged in suicidal activity increases, the numbers of those affected also increases. The survivors of suicide include family, friends, neighbours, and colleagues. Conservative estimates suggest that for each death there are five or six persons who are affected. Given the actual number of deaths in a year, that suicides are commonly underreported by 25%, that an overall estimate of attempts to completed is 100:1, and five persons are affected, the total number of persons affected by suicide deaths (3380) in Canada in the year 1990 (Office of the Provincial Suicidologist), and suicide attempts would be in excess of two million, roughly one tenth of the Canadian population (3380 + 25% x 100 x 5 = 2,112,500). With the impact lasting longer than one year, the cumulative effects of suicidal activity on the population become staggering. This underscores the fact that, although suicide deaths are relatively rare, suicidal behaviour is a relatively common health problem. Prevention and intervention efforts are needed to address the current and anticipated increasing levels and impact of suicidal behaviour (Ramsay, Tanney, Tierney & Lang, 1991).

Suicide Terminology

How we conceptualize suicidal behaviours has important implications for prevention and treatment. One implication is how distinctions among suicidal behaviours relate to treatment interventions. Another implication is the question of whether we can generalize from one type of suicidal behaviour to another. If the distinctions among suicidal behaviours define different populations it would be remiss to generalize predictive correlations or treatment from one population to another. On the other hand, if distinctions classify behaviour and do not discriminate among populations, generalizations about prediction or treatment are appropriate. The current suicide literature uses suicide terminology inconsistently and interchangeably which confuses the results and generalizability of many suicide studies to which we look for guidance in prediction and treatment.

The terms used to define, distinguish and classify suicidal behaviours reflect different components of suicidal behaviour. The term suicide is commonly accepted as meaning fatal self harm, distinguished primarily on the basis of outcome and intent. Outcome as fatal or non-fatal is self evident. Intent on the other hand is a thorny issue, and less clear. Conceptual treatments of intent, such as Douglas' (1967), focus on a number of different components including the initiation of action, the ability to choose, will, rationality and knowledge. These components attempt to clarify intent in terms of awareness, volition and choice. 'Deliberateness' becomes central to intent; which is then clouded by the concepts and role of denial, the unconscious, and to a lesser extent, knowledge. Suicidal intent is usually recognized by the specificity and deliberateness of the suicide plan, and the awareness and knowledge of the method to be lethal. Lethality is understood in terms of the method's probability to produce a fatal outcome.

Suicidal behaviour and suicidality are generic terms that include a variety of suicidal activities. Suicidal ideation refers to thoughts of death and thoughts of one's own death, including thoughts of the deliberate intent to kill oneself. Most commonly the term attempted suicide is used to describe self harm that is non-fatal regardless of intent. Distinctions among non-fatal suicidal behaviours discriminate between parasuicide and attempted suicide on the basis of intent. Parasuicide and suicidal gestures, are considered to include threats of death and physical self harm not intended to result in death. Attempted suicide refers to intended, but non-fatal, self harm. Self harm and self injury are terms used with less agreement, sometimes referring to parasuicide and at other times, to attempted suicide. Acute suicide risk refers to suicidal behaviour thought to be imminent and at a high risk of causing death. Chronic suicide risk refers to repeated suicidal crisis rather than a continual state of suicidality.

Conceptual attempts to deal with generalizabiity among different classifications of suicidal behaviour have focused on whether suicidal behaviour defines one or many populations. The one population perspective considers suicidal behaviour to exist on a continuum, with ideation at one end and death at the other. This single population view includes all acts of self harm, with the common bond being thoughts of death. Two population views discriminate between completed and attempted suicide, considering them two distinct yet overlapping populations. Multi-population views discriminate among suicidal behaviours on the basis of outcome and intent, considering suicide, attempted suicide and parasuicide as different groups or populations (Lineham, 1986).

Research on the relationship between completed suicide and ideation, threats and attempts have shown that suicide rates increase for individuals who ideate, threaten, or attempt (Brent, Kupfer, Bromet & Dew, 1988). Multiple attempters have been shown to be at higher risk for completed suicide (Maris, 1981; Tuckman & Youngman, 1968). Higher rates of repeated suicidal behaviour have been shown for those with low lethal attempts who do not elect treatment compared to those who receive treatment (Greer & Bagley, 1971). Those with suicidal behaviour and a psychiatric diagnosis, and those who abuse alcohol, have also been shown to be at elevated risk (Brent et al., 1988; Pokorny, 1966). Those with ideation including a plan, or those who threaten, have been shown to be at as great a risk as those who attempt (Pokorny, 1966). Individuals who call crisis centres have been shown to be 25 times more likely to suicide than members of the general population (Dew, Bromet, & Brent, 1987). The likelihood of a method to produce death is often considered to indicate degree of intent. It has been shown that the lethality of an attempt is not significantly related to intent (Beck, Beck & Kovacs, 1975; Brent, 1987), except for those attempters whose knowledge of a methods' lethality was accurate (Beck, Kovacs & Weissman, 1979).

For the clinician, distinctions among types of suicidal behaviour are less important than the presence of any suicidal behaviours, as suicidality in any form may become fatal. All types of suicidal behaviour require sincere attention. In that suicide is a relatively rare event a large number of individuals will not kill themselves and will share the same characteristics of those who do. Ten percent of attempters complete, 90 % do not, creating a high number of false positives (Maris, 1981). Treating false positives is an important issue when considered in relation to achieving the maximum benefit of limited resources, and less of an issue when considered in terms of the expected benefits for those who receive treatment. The 90 % of attempters who do not complete (parasuicides and self mutilators) would benefit from effective treatment, as would first try completers, if they had been identified and received effective treatment.

Of more concern for prevention and treatment are the false negatives; that is, those thought to be at a relatively low risk who die by suicide, as well as those who die having sought treatment, while in treatment or having left treatment. Seventy percent of suicides communicate suicidal ideation prior to suicide (Kovacs, Beck & Weissman, 1976; Robins et al., 1959; Stengel, 1964), 40-60 % of suicides consult a physician within one month prior to suicide (Barraclough et al., 1974; Robins et al., 1959;), 35-50 % of suicides have had contact with a mental health professional (Fawcett, Clark & Scheftner, 1991), 30-40 % of suicides have made a previous attempt (Maris, 1981), 40-50 % of suicides are or have been in some form of treatment (Bagley & Greer, 1971; Barraclough et al., 1974; Robins et al., 1959; Weissman, Fox & Klerman, 1973), and 5 % of suicides are inpatients (Crammer, 1984). Professionals often do not detect suicidal behaviour (Coombs, Miller, Alarcon, Lee & Morrison, 1992). Physicians have been shown to detect only one in six who go on to kill themselves (Barraclough et al., 1974; Murphy, 1972). The highest risk of actual suicide following an attempt is during early treatment or immediately following discharge (Pokorny, 1966; Roy, 1982). High repeat rates have been shown to exist for the first 6 months to a year, and that elevated risk continues, compared to the general population, for a period of two to five years following an attempt (Fawcett et al., 1991).

That so many have reached out, communicated their intent, sought help and have still died raises questions of the adequacy of prediction, assessment and treatment. And of particular importance is the question of the adequacy of helpers' knowledge and ability to apply that knowledge in assessment and treatment. For the clinician the issue of major importance is not when or if to treat, but how, and the efficacy of treatment. The need for treatment is indicated by the presence of any suicidal behaviour. The type and delivery of treatment is directed according to how suicidal behaviour is conceptualized.

Suicide Theory

Traditional Approaches to the Study of Suicidal Behaviour

There are a number of traditional approaches to conceptualizing suicidal behaviour, each with its own view and contribution to understanding suicidal behaviour and directing treatment. Table 1 presents a summary of traditional approaches and their focus in conceptualizing suicide.

Table 1

Traditional Approaches to the Study of Suicidal Behaviour

Tradition	View of Suicide
Demographic	Through statistical data
Sociological	Through relationship to society, culture
Life History	Through response patterns, historical suicides
Personal Documents	Through diaries, poetry, suicide notes, art
Systems	Through interactions in a system, family
Biological	Through biochemical imbalances, genetics
Psychiatric	Through mental illness
Psychodynamic	Through unconscious conflict, object relations
Philosophy/Theology	Through views of God, meaning of life & death
Psychological	Through the mind and mental processes

Through each of these views a piece of the suicide puzzle is brought into focus, but no piece addresses the whole of the phenomenon. Extensive research within the different traditions has identified a myriad of discrete factors. Fifteen of the most commonly identified factors related to suicide are presented in Table 2. Each one has been researched extensively. In all suicides it is likely to find the presence, combination and interaction of these fifteen factors. They form the foundation upon which typologies and models of suicide are based, and are ultimately the factors to which the majority of treatment is directed.

Table 2

Common Single Factors of Suicide

1. Depressive illness, mental disorder
2. Alcoholism, drug abuse
3. Suicide ideation, talk, preparation, religious ideas
4. Prior suicide attempts
5. Lethal methods
6. Isolation, living alone, loss of support
7. Hopelessness, cognitive rigidity
8. Being an older white male
9. Modelling, suicide in the family, genetics
10. Work problems, economics, occupation
11. Marital problems, family pathology
12. Stress, life events
13. Anger, aggression, irritability, 5-HIAA
14. Physical illness
15. Repetition and comorbidity of factors 1-14, suicidal careers

(Maris, Berman, Maltsberger & Yufit, 1992, p. 9).

Classification, Typologies and Models

Theoretical formulations have evolved and others have been validated through the study and identification of discrete factors related to suicidal behaviour. A number of models, typologies and classification systems (Maris et al., 1992) clarify the nature, complexity and differences among types of suicidal behaviour, and the meanings and motivations of those behaviours. Each one begins to shape a perspective that directs suicide prevention and treatment. Table 3: Classifications, Table 4: Typologies and Table 5: Models present summaries of notable contributions and the focus they provide towards understanding and conceptualizing suicide and suicide interventions. 'Behaviour' refers to suicidal ideation (SI), attempted suicide (AS) and completed suicide (CS).

Table 3

Classification of Suicide

Classification	**Behaviour**	**Focus**
Beck Committee	SI,AS,CS	Classes of Suicide
Jobes	CS	Classes
Ellis	SI,AS,CS	Factors (causes)
Maris	SI,AS,CS	Classes

Given the variation in self destructive behaviours, classification systems encourage a standardized language and understanding of these activities. Beck's scheme classifies suicidal behaviour as completions, non fatal attempts or ideas, with each type further specified by certainty, lethality, intent, mitigating circumstance and method. Jobes elaborated on the Beck scheme, further delineating completed suicide. The Ellis system encompasses all types of self destructive behaviour, but is considered to confuse classes with causes as it includes a variety of dimensions which differentiate but are related to explanation. Maris' scheme classifies type, secondary characteristics and indirect self destructive behaviours.

Table 4

Typologies of Suicide

Typology	Behaviour	Focus
Durkheim	CS	4 types, social integration
Freud & Menninger	CS	3 types, dimensions
Baechler	AS,CS	11 types, meaning

Typologies reflect disciplinary biases; and Durkheim (1951), as a sociologist, focused on social integration. He postulated four pure types and seven subtypes of suicide. The basic four are anomic, egoistic, altruistic and fatalistic, with each resulting from a type of integration with society. The focus was not on individuals but on broad social conditions. The pure types are mixed in individual suicides. Psychological and psychiatric types of suicide, postulated by Freud and Menninger, were based on three dimensions: hate, depression and guilt, which were reflected as a wish to kill, a wish to die and a wish to be killed. Baechler's typology delineates motives in more detail, including non-fatal suicidal activity.

Through the different views provided by the traditional approaches to suicide we have learned of the multiple aspects of suicide. Suicidal behaviours have been classified and clarified, initiating the beginning of an understanding of suicidal motivations and dynamics. Researchers have identified a myriad of factors and noted the 15 most common to suicide. Given all this, what remains clear is that the relationships among psychopathology, suicide attempts and suicide completion are complex, dynamic and not well understood (Peterson & Bongar, 1990). Attempts to integrate what is known, theoretically and in a useful and practical manner, have produced a variety of models. Table 5 presents a summary of models dedicated to bringing together the accumulated knowledge and advancing our understanding of this complex phenomenon.

Table 5

Models of Suicide

Model	**Behaviour**	**Focus**
Blumenthal	AS,CS	Overlap model: life dimensions
Maris et al.	SI,AS,CS	General Model: dimensions x factors
Motto	SI,AS,CS	Risk: Psychosocial factors, meaning
Lettieri	SI,AS,CS	Risk Assessment: 7 weighted factors
Ringel	SI,AS	Pre-suicidal syndrome
Moss and Hamilton	SI,AS	Multiphase; coping and context
Lineham	SI,AS,CS	Emotional regulation, skills
Shneidman	SI,AS,CS	Ten Commonalities of Suicide
Shneidman	SI,AS,CS	Model: Pain, Press and Peturbation
Kelly	SI,AS,CS	Cognitive constructs
Beck	SI,AS,CS	Depression, Hopelessness
Breed	SI,AS,CS	Suicidal Syndrome: 5 factors
Miller	SI,AS,CS	Suicidal Syndrome: 3 factors

Models of Suicidal Behaviour and Treatment

Of these models, two postulate a comprehensive general model of suicide and attempt to incorporate the multitude of individual risk factors and data generated from the various traditions of viewing suicidal behaviours.

An overlap risk model. This model proposes that the presence of contributing factors from five domains increases the risk of suicide (Blumenthal, 1990). The five domains are psychiatric diagnosis, personality traits and disorders, psychosocial and environmental factors, genetic and familial variables, and biochemical factors. The model suggests why only certain individuals within a specific factor category attempt or suicide. It doesn't distinguish the level of a factor or the degree of overlap of all factors that is significant in precipitating a suicidal crisis. This model acknowledges the complex interaction between personality, psychiatric diagnosis and social context in relation to suicide. It tends to be static, leans toward the biophysical, and underplays the significance of cognitive processes, affect and existential issues. Treatment based on this model is delivered according to the factor domains conceptualized and identified as being involved. By the nature of the model, treatment is typically uni-dimensional and focusses on biophysical and chemical factors.

A general model of suicidal behaviour. This model incorporates major domains or life dimensions as does Blumenthal's model, and combines them in interaction with four different factors: predisposing, risk/vulnerabilities, protective, and precipitating/trigger (Maris, Berman, Maltsberger & Yufit, 1992). Each of the life dimensions interacts with these factors in a process that leads individuals to their personal threshold of pain and a suicide zone in which suicide may occur. Throughout the process individuals encounter feedback loops in the form of treatment, support or situational change which may deliver them to an outcome other than suicide. It is believed that completed suicides move through the suicide zone to protective factors and/or further risks/vulnerabilities and precipitating/trigger factors before they complete suicide. This model tends to be more 'process' and 'events' sensitive. It draws from the work of many suicidologists, encompassing interactive effects over time and the life cycle. Each of the life dimensions x factor interactions have direct implications for treatment interventions.

This general model is the most comprehensive to date, and signifies a leap from conceptualizing suicidal behaviours in terms of discrete single factors to an overall model acknowledging interactive factors within the individual and between individuals and the environment, while remaining sensitive to causative and curative factors. As a general model it provides a comprehensive understanding of suicide dynamics with implications for treatment across a number of dimensions and factors. It is predictive of group vulnerability, but lacks the specificity to determine imminent individual risk.

Risk assessment models. These models seek to identify and predict those individuals at immediate and/or highest risk. In order to intervene and prevent death by suicide, these models assist in determining where individuals are in relation to their life dimensions, the interacting factors and the suicide zone of Maris et al's. (1992) model. A comprehensive risk assessment model is Motto's (1991) Integrated Assessment of Suicide Risk, which provides an understanding of the multiplicity of factors and how they interrelate and converge to yield prediction. Lettieri's (Beck, Resnick & Lettieri, 1974) brief model, which has been popularized through its use in suicide prevention training programs and suicide prevention centres, is used primarily to assist in determining imminent risk (Ramsay, Tanney, Tierney & Lang, 1991). Five factors are differentiated relative to their perceived importance as 'indicators' or 'predictors'. The indicators are stress and symptoms, and the predictors are current suicide plan, prior suicidal behaviour and resources. The combination of these factors, with the predictors considered as primary, is considered to signal the degree of immediate risk.

Fawcett and associates (1988; 1991) identified, quite differently, the relative importance of factors predictive of acute short term risk and chronic or long term risk. They identified the factors associated with imminent risk to be anhedonia, anxiety, panic attacks, depressive turmoil, moderate alcohol abuse, and mood cycling. The factors they identified as associated with long term risk, 2 - 5 years after initial assessment, were suicide ideation, suicide attempts, moderate severity of attempt and intent.

Albeit with conflicting differences among the weighting and priority of factors, both Lettieri and Fawcett and their associates identify essentially the same factors as being important in determining risk to facilitate interventions and avert deaths by suicide. A variety of other risk assessment scales have been developed in the service of prediction (Bongar, 1991). These instruments assist in determining an individual's need for treatment, and they identify specific etiological factors which may be helpful in directing treatment interventions.

A criticism of risk assessment scales is that they do not approach the level of predictive accuracy achieved by simply asking the individual about suicidal concerns (Lester, 1974). Further, the "gross limitation of assessment lies in the assessment of personality strengths which often contribute more to the outcome of a crisis than the pathological elements" (Motto, 1974, p.92).

Prediction that generates awareness and leads to identification and intervention prior to the first attempt provides a powerful service in the prevention of deaths, particularly in light of data showing that 60-70 % of all suicides complete on the first suicide attempt, and that 90 % of males, 45 years and over, complete on their first suicide attempt (Maris, 1981). This is particularly salient for men, who complete more frequently than women at all ages across the life span. Risk assessment models alert caregivers to the factors involved and provide a method of determining risk. They do not generate an understanding of the complexity or the dynamics of suicidal behaviour.

Psychological models of suicide move us closer to the life of the individual and the dynamics of suicide. They attempt to get "inside" and deal with the interaction between what is happening to (external) and within (internal) individuals as they transit in their life dimensions, the factors to and from the suicide zone. Maris et al's. (1992) general model describes the life dimensions, factors and the suicide zone while psychological models describe the dynamics and interaction among these components. Psychosocial, medical or psychiatric treatments address these factors and dynamics. Most therapies are delivered and assessed as a uni-dimensional treatment, focused on either an affective, cognitive, behaviourial, interpersonal or biological therapy.

The knowledge gained from traditional approaches to suicide has been primarily directed towards assessment and prediction. Only a few models specific to suicide treatment have evolved from the accumulated research. Of these, the psychological models demonstrate an interest in the phenomenology of suicide in the life of the individual. The perspectives they offer are more immediately connected to, and directive of, treatment interventions. Such models are Ringel's (1973) Pre-Suicidal Syndrome, Breed (1972) and Miller's (1967) Suicidal Syndromes, and Kelly's (1955, 1961) Cognitive Constructs. Models devoted specifically to suicide treatment are suicide cognitive therapy (Freeman, Simon, Beutler & Arkowitz, 1989; Freeman & Reinecke, 1993), based on the work of Beck (1974), Moss and Hamilton's (1956) Suicide Therapy, Lineham's (1987 a,b) Dialectical Behaviour Therapy and Shneidman's Ten Commonalities of Suicide (1985) and Theoretical Model of Pain, Press and Perturbation (1987).

The pre-suicidal syndrome was proposed by Ringel as early as 1949 (Ringel, 1973). This model dealt with aspects that Ringel identified as commonly occurring with suicidal clients. Ringel's formulation, focused on etiology with treatment implications, included three components: constriction, inhibited/auto aggression and suicide fantasies. The component of constriction included situational, social, emotional, cognitive and values constriction. Values constriction included the inability to appreciate life or self, and the inability to act to realize values concepts. The components of inhibited/auto aggression and suicide fantasies bear resemblance to Lettieri's risk factors associated with high risk, particularly the importance of a specific suicide plan signalling imminent and high risk. Ringel's description of a sense of extreme emergency coupled with a lack of appreciation for life and self is comparable to Fawcett et al.'s (1991) findings of short term risk being associated with anhedonia, anxiety, panic attacks and depressive turmoil. The inability to realize values concepts and life goals is integral to the formulations of helplessness and hopelessness articulated by Beck et al. (1975). Ringel's model encompassed and anticipated many of the discrete factors later identified as related to suicidal behaviours, and predates many of the models of typology and treatment. It directs treatment to resolve the constrictions and emotional turmoil. Treatments and strategies with suicidal individuals are rarely embedded in an overall rationale of suicide treatment, and Ringel's model provides a compelling, comprehensive conceptual model useful in guiding treatment.

Moss and Hamilton's (1956) model delineates phases of treatment and treatment strategies. This model's acute, convalescent and recovery phases incorporate a variety of interventions such as uncovering meanings, feelings, unsatisfied needs and strivings; reframing the attempt as problem solving and searching for new solutions. Emphasis during treatment was placed on the atmosphere, so that interventions occurred in a context of support and caring to modulate the effects of anxiety and self blame. A 90 % reactivation of suicidal behaviour was noted when individuals returned to their precipitating environment. Moss and Hamilton advocated the necessity of major changes in life situations in order for recovery to occur. This model unifies interventions within a treatment rationale.

Dialectical behaviour therapy (Lineham, 1987, a,b) presents a contemporary model of treatment. This formulation revolves around three behavioral patterns, each viewed along a continuum of polar opposites:

emotional vulnerability - invalidation, active passivity - active competence, and unrelenting crises - inhibited grieving. Lineham posits that the first pole of each behaviourial pattern continuum (emotional vulnerability, passivity, unrelenting crises) is influenced by biological factors associated with emotional regulation, with the opposite set of poles (invalidation, active competence, inhibited grieving) being influenced by social responses to emotional expression. Treatment includes cognitive, affective and behavioral components focusing primarily on emotional regulation and the acquisition of skills to promote personal effectiveness and problem solving.

The ten commonalities of suicide provide an integrated compilation of the psychological underpinnings of suicide (Shneidman, 1985). In its simplicity of ten points this model includes affective, cognitive, behavioral, existential, and interpersonal components, and it connects the internal world of the individual to the external world of events through an emphasis on the importance of idiosyncratic meanings to the individual. For each commonality there is a treatment directive as to what must be understood and resolved for healing and movement away from suicidal behaviour. The ten commonalities are presented in Table 6.

Shneidman (1987) combined the ten commonalities in a three point model of pain, press and perturbation. In this model, pain refers to the frustration of psychological needs; press refers to aspects of the inner and outer world that impinge on a person and make a difference; and perturbation refers to perceptual constriction and the penchant for action. According to this theory, when pain, press and perturbation converge an individual may suicide. Of the myriad factors that may be identified as involved, only those factors that bear on presently felt pain, negative press and perturbation are salient to suicidal behaviour. All other factors are peripheral. For healing to occur the level and intensity of pain, press and perturbation must be lowered.

Table 6

Ten Commonalities of Suicide

	Commonality	Treatment Directive
1.	Stimulus: (unbearable pain)	Reduce the pain.
2.	Stressor: (frustrated needs)	Fill the frustrated needs.
3.	Purpose: (to seek a solution)	Provide a viable answer.
4.	Goal: (cessation of consciousness)	Indicate alternatives.
5.	Emotion: (hopelessness-helplessness)	Give hope.
6.	Internal attitude: (ambivalence)	Play for time.
7.	Cognitive state: (constriction)	Increase the options.
8.	Interpersonal act: (communication of intent)	Listen to the cry. Involve others.
9.	Action: (egression)	Block the exit.
10.	Consistency: (life long patterns)	Invoke previous coping pattern.

(Shneidman, 1987)

Kelly (1955, 1961) and Beck (1974) presented models of the cognitive components of suicide. Kelly's psychology of personal constructs is based on the perspective that individuals formulate constructs from life experience, which are then imposed on and tested against reality in order to give meaning and make sense out of experience. This representation of events in abstract constructs is a life long process providing a map of life and an understanding of how to behave and what to expect in the world. When life delivers events for which constructs do not apply, effort is required to revise the construct system. Challenges to the system are experienced as threat, fear, anxiety, guilt and hostility. Suicide becomes an option when constructs confirm the worst expectations, or when one's constructs are perceived to be invalid. When one's construction system is wrong, the identity and self they form falls apart. When constructs fail, there is no sense of self or meaning, only absolute anxiety and uncertainty. From this position Kelly views suicide as a bid for certainty in the face of chaos, an adaptive validational act.

Beck, Kovacs and Weissman (1975) view hopelessness as the central component of suicide. Depressed individuals become suicidal when they become hopeless and believe no options exist. This sense of hopelessness accrues from the elements of Beck's cognitive theory of depression: the negative triad comprising a negative view of self, world and experience; errors of perception and processing; and dysfunctional assumptions.

Cognitive structures or constructs are organized representations of prior experience that facilitate memory and recall. They may include distortions in the initial construction or later reconstruction. Disturbances in early life are a major source of the development of dysfunctional representations of self, cognitive constructs or schemas (Bowlby, 1980). Cognitive structures are also considered to include an affective component described as a meaning structure (Lundh, 1988) encompassing knowledge, beliefs, emotions and motivational aspects.

Cognitive-behaviourial therapy focuses on an active restructuring of an individual's thoughts, behaviour and meaning, with meaning linking cognition to affect. Cognitive therapy encourages reality testing by developing and testing hypotheses, and teaching problem solving as ways to offer alternatives and options, thus countering feelings of hopelessness.

Miller (1967) and Breed (1978) offer models of the dynamics of suicide. Miller's model includes three components: commitment, communication and crisis. Breed's model has five components: commitment, rigidity, failure, shame and isolation. The essence of these models is that when an individual experiences a crisis through change or failure of a strongly committed role, along with social isolation, disrupted channels of communication, rigidity and a sense of shame, the individual is not open to take in new information that would allow shifts in behaviour or an innovation in the definition of the self. Feelings of worthlessness and despair spiral the individual into suicidality as the individual cannot live without self esteem and a secure sense of self. Treatment is directed towards altering the dysfunctional components.

The Self in Suicide and Treatment

The construct of the self is becoming an increasingly important element in theroetical and treatment models. Different views of the nature of the self in relation to suicide are offered by different theoretical approaches. As long ago as 1969, Farberow recognized the importance of the self in suicide and reviewed the literature with a view to the connections between identity and suicide. He noted the major contributions to understanding the self in suicide were from psychoanalytic ego psychology, object relations theory and social psychological perspectives.

Early psychoanalytic theory postulated the ego as a set of defenses against strong inner drives, and this was reflected in Freud's and Menninger's typologies of suicide. Ego psychologists viewed the ego as more than a regulating apparatus, and understood it as a way of functioning assisting individuals adapt to their experience. Erikson's (Ryckman, 1982) ego psychology proposes a theory of identity formation. Maris (1981) concluded from observations that most suicides occur at interstices of Erikson's stages and later developmental periods, and that suicide could be predicted on the basis of failed developmental tasks and developmental stagnation.

Social-psychological perspectives of the self include the reflected and object self of Cooley and James (Farberow, 1969), role theory (Gibbs & Martin, 1958, 1974; Henry & Short, 1957) and the symbolic interactionist viewpoint of Mead (Miller, 1967). These theoretical conceptions of the self regard the development of the self as occurring through a process involving the ability to take the role of the other, the ability to evaluate the self, and the ability to make adjustments to reflections and evaluations. Breed's and Miller's models illustrate this conception of the self.

Cognitive models of the development of the self are based on the perspective that "man contemplates in his own personal way the stream of events upon which he finds himself so swiftly borne" (Kelly, 1955, p. 3). Kellys' constructivist model asserts that life's experiences do not impose meanings, rather it is the individual who construes to make sense out of experience. The self is viewed as being formed and experienced through a set of personal beliefs or constructs. The self's ability to constantly evaluate is central to the development of the self and to theories of suicide.

The various perspectives of the self, the self's essential dimensions, the role it plays and the process of self development each deal with the way experience is integrated into the self system. Conflict within the self system and its resolution, which occurs during the integration of experience, is related to the development of suicidal behaviour. Kelly's (1955, 1961) theory of personal constructs and Beck's (1974) negative triad describe and direct treatment to address the self system's beliefs and cognitions which formulate the self concept.

Roger's (1959, 1961) person centred psychology shares with cognitive psychology similarities in relation to the development of the self, with self formulation seen as occurring through the integration of experience into a continually evolving self system. For Rogers the self concept emerges as the individual develops and discriminates among experiences, both those that are the persons own being and functioning and those that belong to others and the environment. A sense of self is acquired from experiences that belong to the person's own being and functioning. This development is strongly influenced by the individual's perception of experience, and by the need for positive regard, a universal need in human beings. Rogers describes self regard as a learned sense of self which has a life of its own independent of actual experiences of regard. Self regard becomes a pervasive construct governing behaviour and overpowering organismic needs. From this view, experiences are perceived selectively according to their fit with the sense of self and conditions of worth. To maintain self regard individuals act in accordance with conditions of worth (essentially approval from others), and choose positively valued attitudes and actions and avoid or deny organismic experience learned to be not worthy of positive regard (lack of approval from others). Experiences that run contrary to the sense of self and learned self regard are distorted, denied and experienced as a threat. The lack of congruence, or the dissociation between self and experience is believed to be the basis of pathology and the development of suicidal behaviour.

Treatment, according to Kelly and Beck, is to be directed towards altering cognitions and constructs, and for Roger's treatment is directed towards the conditions of worth that promote the development of self regard. The essence of person centred therapy is the provision of positive regard so the individual exchanges the self's learned conditions of worth for positive self regard learned from trusting in one's own organism. Person centred theory and therapy view the attitude of the therapist as necessary and sufficient to effect this exchange. Empathy, genuineness and positive regard are considered to be the catalytic agents in the therapeutic relationship and behaviour change.

Mahoney (1991) provides a new synthesis of the research on cognitions, emotion and the nature of the self. This perspective describes human knowing as active, embodied and fundamentally emotional with the processes of thinking, feeling and doing (and their trajectories over time) reflecting the dynamics of self organization. Central to this view on self organization is the belief that adult relationship patterns are based on original attachment patterns. Therapy or healing is the transformation of these attachment patterns. Mahoney asserts that the forced distinction between cognition and feeling is no longer tenable as the processes of thinking, feeling and action are inseparable expressions of the same system. Mahoney declares "emotionality to be fundamental to beliefs and behaviour" (p. 176). From this perspective the self is fundamentally emotional rather than fundamentally cognitive, with all three processes, thinking, feeling and doing, reflecting the self and self development.

The viewpoints on suicide from the different disciplines, the classification systems, typologies, etiological and treatment models and the different views of the self in relation to suicide, provide the base for current suicide prediction, assessment and treatment. In sum, the accumulated knowledge of the various disciplinary viewpoints indicate that suicide involves a great variety of factors and that the resolve of suicidal behaviour requires an understanding and knowledge of the complexity of suicidal behaviour, including the external observable aspects and the internal dynamics. This accumulated knowledge indicates that treatment requires a willingness to focus and work with thoughts, meanings, feelings, behaviours and biology with an awareness of the context and personal environment of the suicidal individual.

Suicide Prevention and Intervention

Preventing and resolving suicidal behaviour and deaths by suicide, generally, is multifaceted with efforts directed at many different levels. Primary prevention refers to programs designed to reduce rates before any signs or symptoms have appeared. This means providing interventions prior to the development of suicidal behaviour. Examples of such prevention measures are suicide crisis centres, suicide and distress hotlines, regulation of means to suicide, public education programs and school based education and peer counselling programs, limiting media display of celebrity or prominent suicides (censorship) and posting sources for help when airing dramatic productions about suicide. Suicide postvention may become primary prevention given the data on the relationship between suicide and the suicide of significant others, whether extra familial (Gould & Shaffer, 1986) or within the family (Murphy & Wetzel, 1982; Schulsinger, 1979).

Research on primary prevention programs has investigated suicide crisis centres and school based education programs. Reviews indicate the effect of suicide centres is unclear, and the findings do little to support the view they reduce rates of suicide. Nor do research findings offer support for the value of general education programs (Dorwart & Chartock, 1990; Shaffer et al., 1988). Some isolated small scale examples of school based programs show positive impacts on changing attitudes and knowledge related to suicide (Kalafat & Ryerson, 1993). Shaffer et al. (1988) conclude of school based programs that "most students do not need them, and those who do would probably be better served by an individualized approach to their clinical problems. This is not to say, however, that there is no place in the high school curriculum for more education about mental health and how to obtain help for emotional disorder" (p. 681).

Secondary prevention seeks to detect a symptomatic condition at an early stage and prevent the progression of the condition. In terms of suicide prevention, this would be akin to treating conditions and symptomatic behaviour that are associated with a high risk of suicide. Examples of this would be the treatment of depression, substance abuse, panic disorder and self injury.

Tertiary interventions serve to reduce the severity, consequences and recurrence of a symptomatic condition. An example would be to prevent ideators or attempters from completing. Secondary and tertiary interventions are delivered through traditional counselling models typically found in hospitals, community agencies and counselling settings.

Treatment Studies

Psychiatric-Hospital Based Treatments

Few studies have examined treatment effects or compared different treatments in reducing suicidal behaviour. Greer and Bagley (1971) were the first to do so. Their retrospective study of parasuicide compared individuals with no treatment (self or physician discharged) to those who self selected and received brief treatment (two contacts) or prolonged treatment. Lower rates of repeat suicidal behaviour were found for those electing treatment, and the lowest rate was for the prolonged treatment group. These results justified the idea that contact was important but said little about the type of treatment offered. Lower repeat rates were also found for those who were admitted over those not admitted in Kennedy's (1972) retrospective non random study. In studies with random assignment, neither a more prolonged treatment (Chowdhury, Hicks & Kreitman, 1973) or a 3 month task centred treatment (Gibbons, Butler, Urwin & Gibbons, 1978) was more effective than standard outpatient treatments in reducing attempts. Another random study investigated domiciliary treatment compared to outpatient weekly visits, with both settings using a problem oriented approach. No significant difference was shown between the groups, but both showed low rates of repeats (Hawton, Bancroft, Catalan, Kingston et al., 1971). This was the first study that suggested the form of treatment, problem solving in this study, rather than the setting may be a key variable in reducing rates of repeat attempts (Hirsch, Walsh & Draper, 1982). Further studies either supported the hypothesis that social and psychiatric intervention plays a role in reducing suicidal behaviour (Welu, 1977), or demonstrated that outpatient approaches (Ettlinger, 1975) and outreach follow up programs do not significantly alter rates of suicides or attempts (Motto, 1976). Overall, these studies indicate contact may be helpful and the type of treatment important. The treatment descriptions in these studies were not very illuminating as treatment was variously described as outpatient, follow-up, domiciliary or treatment as unusal.

Pharmacological Treatments

A number of reviews have examined the effects of pharmacological treatments for individuals with repetitive suicidal behaviour. Hirsch, Walsh & Draper (1982), Lineham (1986) and Brent et al. (1988) reviewed pharmacological treatments and concluded the only unchallenged improved effects with suicidal behaviour were found by Montgomery using neuroleptics. Studies that compared pharmacological or psychosocial treatments showed lower rates of relapse at one year follow up with the psychosocial treatment (Kovacs, Rush & Beck, 1981; Rush, Beck & Kovacs, 1977; Weissman, 1979). This benefit was related to the lower dropout rates of individuals receiving psychosocial treatments. This is important, as a number of studies indicated suicidal individuals are difficult to get into or maintain in treatment (Paykel, Hallowell, Shapiro & Weissman, 1974).

Short term cognitive therapy and interpersonal therapies have been shown to reduce hopelessness and suicidal ideation in depressed individuals (Kovacs et al., 1981; Rush et al., 1977) and create improvements in hopelessness and self concept (Rush, Beck, Kovacs, Weissenberger & Hollon, 1982). Overall, the evidence indicates a benefit from psychosocial treatments or their combination with pharmacological treatments over pharmacological treatments alone.

Psychosocial Treatments

Psychosocial treatments consist of cognitive, behavioral, affective and interpersonal therapies. Treatments are typically delivered utilizing one of these approaches rather than a combination. The primary focus is on the individual, although several of these therapies include interventions in the environment of the suicidal individual.

Cognitive-behaviourial is the most researched and documented treatment. This approach stems from the pioneering work of Aaron Beck on depression which has been tailored to and shown effective for suicidal individuals (Rush & Beck, 1978). Comprehensive outlines of cognitive-behaviourial techniques and their application with suicidal individuals are documented in Freeman and White (1989) and Freeman and Reinecke (1993). Treatments of cognitive-behaviourial interventions have targeted different components, and assessed a change effect in cognitions and suicidal behaviour following treatment. Studies have found cognitive-behaviourial interventions effective in altering individuals' patterns of logic (Diekstra, Engels & Methorst, 1988); in modifying cognitive schemas (Bedrosin & Beck, 1979; Patsiokas, Clum & Luscomb, 1979; Rush & Beck, 1978; Rush et al., 1982), thought patterns and overt behaviours (Kiev, 1975; Nidiffer, 1980); and in correcting distortions and rigid conclusions (Weishaar & Beck, 1990; Neuringer, 1964, 1971; Neuringer & Lettieri, 1971). The effectiveness of cognitive-behaviourial interventions in producing a change in cognition and reducing suicidal behaviour is based on the premise that, when information and experiences are introduced that challenge the individual's automatic thoughts and beliefs about the self, the situation or suicide, a shift occurs allowing the pattern of thinking to change. Further, when a pattern is open to influence, the established way of processing information is altered and the individual shifts in relation to factors related to high suicide risk: detachment (social withdrawal), negative view of self (self-rated inferiority), helplessness (lack of personal control) and hopelessness (negative view of the future). Although these interventions were found to be effective for many individuals in the studies, many others did not benefit. The assumption was that their pattern was not open to influence, as the interventions did not produce a change in cognitions or suicidal behaviour.

Problem solving approaches were also found effective in remediating depression and suicidal behaviour (Patsiokas & Clum, 1985; Salkovskis, Atha & Storer, 1990; Perlmutter & Jones, 1985). Cognitive reframing and restructuring interventions were also found effective in counteracting the effects of learned helplessness (Seligman, 1975). This was noted as being particulary important for women, as it focused on their experience of helplessness and the accompanying inability to control their lives which frequently results in a tendency to give up and depression (Nickerson, 1977). Treatment from this perspective was conceptualized as "immunizing" against limiting socialization processes and societal contributions to learned helplessness. Treatments stressed the recognition of women's needs and potentials, and focused on restructuring views of the nature of women (Kaplan & Klein, 1990). An alternate vision of the nature of women, based on the work by the Stone Center at Wellesley College, is the view that women's development is qualitatively different from men's. This difference was defined as a relational self structure, denoting a developmental movement towards mutuality for women, rather than separation as accepted by developmental models. This difference underscores the importance and significance of disconnection in suicidal motivation and behaviour in women. The impact of negative early life interactions, disruptions and losses are compounded by this understanding of women.

The impact and importance of the system and situation in which the individual lives and suicidal behaviour occurs has been studied from a number of viewpoints. The context in which suicidal behaviour occurs has been identified as related to stressful events and life changes (Luscomb, Clum & Patsiokas, 1980; Paykel, 1976, 1989). The primary focus of behaviourial-ecology treatments (Jeger, 1979; Foreman, 1990) is the situation or system in which behaviour occurs. These treatments focus on social supports, community enhancement, environmental resources and the individual's power to change situations. Intervention efforts were aimed at training individuals to plan their environments in accord with their own goals and values. Within this framework it was important to make the distinction between existential problems of meaninglessness and the lack of skills or knowledge of how to make something of life.

Cognitive reframing and restructuring, identifying automatic thoughts and behaviour patterns and problem solving strategies, particularly in relation to interpersonal dimensions, were repeatedly focused upon in cognitive-behaviourial therapy to reduce suicidal behaviours. Of the few studies that compared psychosocial approaches, one randomly assigned in-patient comparison found behaviourial therapy to be more effective than insight oriented therapy in reducing repeat parasuicidal behaviour after discharge (Liberman & Eckman, 1981).

Interpersonal therapies and cognitive therapies typically identify a factor related to suicidal behaviour and direct treatment to that factor. Evidence supporting these treatments, clinically and empirically, indicates effectiveness relative to the reduction of suicidal behaviour and improvement on the factor.

A number of treatments focused on reducing suicidal behaviour through determining the feelings and meanings of suicidal attempts. These were expressed in terms of interpersonal dimensions (Leonard, 1967, 1975), interpersonal interactions (Weaver, 1986), frustrated personal needs (Murray, 1972) and expectations (Melges & Weisz, 1971) and the need for social supports and problem solving skills in order to create change in life situations (Murray, 1972).

Understanding the need for affection combined with the fear of social and interpersonal interactions was integral to interpersonal therapies (Nelson, Neilsen & Checketts, 1977). Reducing suicidal behaviour meant dealing with the fears of social interaction believed to be related to previous interpersonal disruptions and altering the hostile and avoidant reactions (Weissman, Fox & Klerman, 1973) to loss and abandonment which were shown to be related to distortions of self image (Glaser, 1978).

Social isolation, withdrawal and loneliness are important factors in suicidal behaviour. The feelings associated with loneliness include boredom, anxiety, hostility, restlessness, general dissatisfaction and unhappiness which act as an alarm signal that social relations are deficit in quality and quantity (Blai, 1989; Glaser, 1978). Loneliness, as the response to traumatic disrupted relationships or unresponsive and non-nurturing parents, jeopardizes an individual's sense of well being and leads to increased risk of depression and suicide (Blai, 1989; Murphy, Armstrong & Hermele, 1979)). These feeling responses to isolation and loneliness are comparable to those identified by Fawcett (1988) as related to high risk of suicide. Interpersonal therapies directed treatment towards establishing personal and social connections, developing social skills and improving self esteem and attitudes.

Treatments dealing with feelings were directed towards emotional expression and regulation, or expressing affect in meaning (Lineham, 1987, a,b; Miller, 1980; Leonard, 1967, 1975). Stress reduction (Clum, Patsiokas & Luscomb, 1979) and anger management (Kolko & Brent, no date) were treated with cognitive approaches. The inability to tolerate feelings and anxiety and the collapse of an individual's functioning (in response to internal and/or external factors) were treated with a focus on supporting the individual through crisis and reactivating or developing defense mechanisms to handle anxiety (Achte', 1990). Treatments directed toward feelings emphasize the importance of social support and contact; understanding the needs the individual was trying to satisfy; problem solving; finding ways to express feelings, specifically aggressive feelings, and blocking impulsivity.

Simply expressing feelings (Nelson & Grunebaun, 1971), and discharging affect (Cavenar & Nash, 1977) were also found to lead to improvements in social adjustment and the reduction of suicidal behaviours. The importance of emotional expression was shown to be important in maintaining emotional connections, as emotional isolation was found to exist in the presence of adequate social and family ties when individuals were unable to appropriately communicate their feelings (Leff & Bunny in Krugley, 1988).

Another affective treatment was based on the belief that most people do not know how to process their emotions, to utilize their affect to gain self knowledge and to follow their feelings to problem identification and resolution. The importance of utilizing feelings in this way was founded on the idea that acknowledging and understanding feelings breeds a sense of being in control, and leads to the construction of the self, identity and a sense of direction. On the other hand, denying feelings and attempting to avoid, diminish, replace or discard them often results in a search for pain killers: alcohol, work, sex and suicidal behaviour (Shapiro, 1985). The goal of this treatment perspective was to develop self knowledge through feelings, to be followed by appropriate problem solving.

One treatment, based on positive affects, utilized positive self statements to modify mood. The premise of this procedure was that it altered abstract associative processes and improved problem solving (Madigan & Bollenback).

In summary, a variety of treatments were shown to be effective in reducing suicidal behaviours. They span a wide range of treatment interventions directed at a wide variety of factors associated with risk of suicide. Overall, the treatments utilized were most commonly based on contact or cognitive characteristics. Although less common, a number of treatments utilized affect as a primary focus of treatment. Affect, as a felt response described in meaning, was viewed as connecting cognitions and context to understand the motivations to suicide. Most affective treatments focused on emotional regulation or expression through pharmacological and psychosocial therapies. The situational and contextual world of the individual was addressed indirectly through altering cognitions and affects, which were expected to ultimately influence how individuals interact with others and situations, and directly through interventions to alter behaviour, interaction, communication and the situation itself.

The major difference between psychotherapy generally and psychotherapy with suicidal individuals is the goal, which is seen typically as resolving the crisis and keeping the individual alive. This goal may also be the root of why some intervention and prevention strategies are not shown to be consistently effective as they do not extend to resolving the underlying issues that brought the individual to a suicidal conclusion in the first place, and without resolve may well, and often do, return the individual to a suicidal crisis another time. A number of treatments emphasized the importance of the system, context and situation moving beyond strict crisis intervention and resolving the crisis to interventions directed at changing the environment or resolving underlying issues. This type of treatment focus does not often occur for suicidal clients.

General Psychotherapy

Few studies of the effectiveness of psychotherapy, generally, were done before Eysencks' (1952) study which showed that psychotherapy was really no more helpful than no therapy at all. Reactions to this study stimulated research to investigate the effectiveness of therapies, the specific effects of different therapies, and that therapeutic change can be accounted for by these effects. Outcome studies that followed Eysenck have clearly supported the favourable effects of psychotherapy (Bergin & Lambert, 1978; Garfield & Bergin, 1978) while showing no consistent significant differences between the various types of psychotherapy (Smith, Glass & Miller, 1980). This finding is consistent with psychosocial outcome studies of suicidal treatments.

Research on therapeutic effectiveness has investigated numerous variables to determine the mechanisms of change; namely, client characteristics (Garfield, 1978), therapist characteristics (Parloff, 1978), the therapeutic relationship (Frieswyk, 1985; Patterson, 1984) and non-specific treatment factors (Wilkins, 1979). More often, non-specific factors are not articulated and are considered to be those factors common to all treatment modalities, such as credibility and expectancies (Kazdin, 1979) or Roger's (Corsini, 1984) necessary and sufficient conditions of empathy, positive regard and genuineness.

The search to determine the effectiveness of therapeutic variables has evolved taxonomies of helpful and non-helpful events (Elliott, 1985) and stages of change, which bridge the measurement and understanding of interventions that facilitate or prohibit change. Stages of change approaches focus on process variables, when psychotherapy is seen as a process leading the individual to new levels of meaning and self organization (McConnaughy, DiClemente, Prochaska & Velicer, 1989) brought about by progressive layers of cognitive reframing (Katakis, 1989), or emotional processing (Clarke, 1989; Greenberg, Rice & Elliott, 1993; Johnson & Greenberg, 1989).

Errors of Treatment

Another view of the effectiveness of therapy comes from studies of treatment errors. Within the suicide literature a variety of reviews have documented errors, either by omission or commission, which have contributed to suicidal acts. The violations of expectations and standards have resulted in malpractice actions. The outcomes of these actions are based on practice standards and the determination of cause, either as failure to protect and prevent suicide or as direct causation. Expectations to protect or prevent suicide are more stringent in custodial care and less so in counselling practices due to differences in the ability to control behaviour.

The responsibility to protect and prevent suicide requires initiating preventive measures with high risk suicidal individuals. The determination of high risk is based on the assessment variables related to acute risk; the individual's history, previous attempts, the communication of intent and the seriousness of mental state. Liability for the failure to take preventive measures when events could be foreseen requires attending to these factors and intervening with safeguards and the supervision of a highly suicidal individual (Swenson, 1986). The decision to emphasize positive behaviours and to not bring the suicidal despair and picture of the world out into the open may contribute to a suicidal act. These studies of errors indicate that it is important to confront, explore and discuss the suicidal decision, determine the degree of lethality, and undertake interventions to protect, including contracts, informing others or hospitalization (Wubbolding, 1987).

Direct causal links or iatrogenic suicide have been determined as a result of breaches of confidentiality, dispensing lethal quantities of medications, directives for action (inappropriate therapy), direct harm and nurturing dependence then abruptly terminating. Only the most blatant indiscretions have been upheld as violations of standards (Swenson, 1986).

Psychological autopsies of suicide deaths revealed five common errors in managing suicidal individuals: the failure to use appropriate therapy, the attitude suicide was inevitable and the case hopeless, the failure to assess an individual's communication as suicidal, the failure of staff to communicate, and the return of individuals to the contributing social system (Kreiger, 1978). Some of these errors are setting specific and relate to the degree of responsibility accepted in custodial care and expected as standards of practice.

Integral to standards of care is the provision of appropriate therapy. Psychotherapy presupposes more than the administration of medications to suicidal individuals. The delivery of appropriate treatment requires understanding the individual's life situation, the precipitating and contributing events, the individual's long term interaction style and the motivations for suicidal behaviour. It requires therapists to be active, direct and personal; willing to work cooperatively and not take over the life of the suicidal individual (Jorstad, 1987). A constellation of factors identified as responsible for therapeutic failure with fatal consequences included the failure to cope with clients' aggression, to tolerate client dependency, to handle erotic transference, and to preserve loyalty to the client (Modestin, 1987). Effective therapy with suicidal individuals requires a good working relationship and an understanding of transference and countertransference (Jorstad, 1987; Maltsberger & Buie, 1974; Modestin, 1987).

Clients' transference affects (feelings projected onto the therapist) and therapists' countertransference affects (feelings stimulated through the interaction, client transference, and therapist projection onto the client) may be particularly intense during treatment with suicidal individuals.

> Awareness of these feelings provides us, firstly with the possibility of controlling them, and secondly, with the possibility of using our countertransference reactions as a tool to understanding the intensive feelings of the patients and their background, both in the present and in the past. However, if we are not aware of our countertransference reactions, we risk acting out of these emotions, and thereby, without knowing, contribute to a suicidal crisis or act. (Jorstad, 1987, p.78).

Maltsberger and Buie (1974) addressed the phenomenon of countertransference hate and its danger to suicide. They saw countertransference hate as a combination of aversion and malice, when aversion tempts the therapist to abandon the client, and malice involves sadistic torturing impulses. Aversion and abandonment were considered the most likely to precipitate a suicidal act. On the other hand, malice was tolerated for long periods of time and only when it stopped and withdrawal took place was the likelihood of suicidal behaviour increased. Acting on countertransference affects is antitherapeutic and unacceptable, and the recognition and handling of this component of the treatment relationship is vital for effective treatment.

The successful treatment of suicidal behaviour requires interventions from the various levels of primary, secondary and tertiary prevention (Maltsberger, 1991). This includes adequate education about suicide for professionals to enable recognition, and the necessity of a thorough exploration of depression and suicidal impulses when any depressive symptoms were disclosed and the adequate treatment of depression. Maltsberger (1991) advocates the consideration of continuous custodial care or the use of somatic treatments with persistent suicidality. He concluded that when all treatment alternatives have failed to relieve suicidal pressure,

> The patient may be given back some of the responsibility of the choice about living and dying, responsibility that may long ago have been taken away from the patient by involuntary hospitalization... there comes a time when enforced hospitalization becomes meddlesome.... The preferable treatment is to allow chronically suicidal patents...to leave the hospital from time to time, for increasingly long intervals, up to and through discharge, but all the while offering continuing help and hospitalization should the patient wish it. Under these circumstances some patients may hang on to life for many years while others, electing to endure their painful and incurable illnesses no more, may choose to take their own lives (p. 305).

Szasz (1971, 1989) responded to the dilemma of enforced hospitalization of suicidal individuals with the argument that suicide is a basic human right, and that the real or assumed danger of a suicide does not justify coercive means to protect life. He maintains that treatment is to be contractual and not coercive, and given when help is wanted. Rather than not treating, this position is one of when and how to treat and the effectiveness of treatments with suicidal individuals.

Conclusion

Psychiatric-hospital based, pharmacological and psychosocial treatments have all shown some effectiveness in reducing suicidal behaviours. Most of the psychiatric-hospital based treatments focused on one identified factor, a suicide attempt with the main treatment focus being contact. Psychosocial treatments typically conceptualized and delivered treatment in response to a specific factor identified from the multitude of factors associated with suicide. Treatments were considered effective when improvement on the factor correlated to a reduction in suicidal behaviour. Although suicide theory and treatment models identified a number of dimensions and factors to be involved with suicidal behaviour, most reported treatments were uni-dimensional and directed to one factor. It leads one to speculate if all treatments are this uni-dimensional or if the treatments reported are more a function of research and methodology, related to the difficulties and complexities of assessing and measuring multiple variables and internal dynamics.

Methodology undermines the confidence in treatment outcome studies when so few studies were prospective, comparing different treatments, with random assignment or control groups. With the lack of methodological rigour, and the preponderance and complexity of factors associated with suicidal behaviour, uncertainty remains as to which treatment or aspect of treatment was responsible for reducing suicidal behaviour when comparison and control groups were not involved. On the other hand, research attempting to compare psychosocial treatments illustrating the superiority of one over another has doubtful clinical utility, as the vast array of factors identified as being related to suicidal behaviour requires a diversity of treatment approaches. The variety of identified factors and treatment approaches reflect that body, cognitions, behaviours and feelings comprise a dynamic unity and all of these dimensions need to be addressed to reduce suicidal behaviour. For the clinician, how to choose among treatment alternatives remains unclear.

Psychotherapies, suicide treatments and suicide treatment errors each provide a view of the elements necessary in the effective treatment of suicidal behaviours. The difficulty of conceptualizing treatment in an integrated theoretical fashion is directly related to the multitude of factors that have been associated with suicide and suicidal behaviour. There appears to be no one reason why a person suicides, and no one treatment to resolve it.

The primary focus of suicidologists has been on prediction, assessment, and crisis intervention and not on long term treatment. The reviewed treatments did not appear to be on-going, seeking to resolve the underlying issues contributing to suicidal behaviour. In 1961, Shneidman observed that suicidology was headed in the direction of prevention rather than understanding. In 1993, he warned of the dangers of "somaticizing, biochemicalizing, and medicalizing the introspective suicidal dramas" of individuals' lives (Callahan, 1993, p.7). This caution on treatments losing sight of the humanity of suicidal individuals is extended to methodologies when "the individual is rarely the primary source of improvement verification, as if the person is biased against his own case! This is methodologically accidental, but is nevertheless important. What passes for objectivity objectifies the subject as object, and leads into a paradoxical distrust of psychotherapeutic method" (Budge, 1983, p. 299). The person's view of their complex and multifaceted internal experience has been ignored in favour of external, typically single, measures of the dynamics of suicide and healing.

To prevent and remediate suicide and suicidal behaviour requires understanding the dynamics of suicide and the dynamics of healing for the individual. Theoretical models and outcome studies offer perspectives on understanding suicide, directing treatment interventions and the effectiveness of treatment. The application of what we have learned, and the pursuit of further knowledge, is important to deal with the increasing rates of suicidal behaviour and the knowledge that current assessments and treatments have failed many - those who have communicated their intent, sought and received treatment and have still died by suicide. Another perspective on what is helpful in resolving suicidal behaviour is available through asking those who were once suicidal the question, "What was helpful in healing from suicidal behaviour?" Individuals' stories, their experiences and processes of healing would add another view to the existing perspectives of the theorist, therapist and observer.

CHAPTER THREE

METHODOLOGY

The Question

The intent of this research was to explore the process of healing from suicidality, to discover what made a difference between living and dying in the lives of suicidal individuals. This being the quest, methods were explored to determine an effective vehicle to study healing from suicidality.

Review of the literature indicates that research has investigated theory and treatment from a natural science perspective. Outcome studies sought, through the experimental method and the manipulation of variables, a change effect. This positivistic approach seeks lawful and determined relationships upon which to base explanation and prediction. Natural science objectifies phenomena, lending an air of precision and exactitude, rather than viewing phenomena experientially. Phenomena are studied in measurable, observable, duplicable, and operational terms to eliminate subjectivity, considering experience unreliable and not trustworthy (Colaizzi, 1978). A foundation of natural science is objectivity or unprejudiced observation. "It is objective because it is not burdened by the complications of the various ways people might experience...: objectivity resides wherever experience is not.... (another perspective on objectivity is) When someone is said to be objective, it means that his statements faithfully express what stands before him, whatever may be the phenomenon that he is present to: objectivity is fidelity to phenomena. It is a refusal to tell the phenomena what it is, but a respectful listening to what the phenomena speaks of itself" (Colaizzi, 1978, p.51-52).

Dilthey (1977) discriminates between two approaches to research, natural science and human science, distinguished by separating events which are caused and require explanation from acts which are intended and require understanding. Traditional research has tended towards natural science and the quantitative experimental method focused on explanation. Human science and qualitative methods focus on discovery and utilize a variety of descriptive methodologies to acquire understanding.

Understanding, for subjects and researchers, requires personal participation. Through experience and involvement, access to understanding is acquired through the lived relation between the object of knowledge and the researcher. "For any object of study is a product of this body-object relation, this system lived body-lived world. (described) In Merleau-Ponty's descriptive 'inhabit,' in Polyanyi's 'indwelling,' in Gendlin's bodily felt meaning, and in Ricoeur's 'appropriation'" (Shapiro, 1986, p. 173). Human experience is always world involved experience.

> Ordinarily, while we might grant that experience does exist, we tend to locate it inside us. "Oh," we might say, "sure, I have experience, but my experience is inside me and it doesn't exist out in the real world, and therefore, even though it does exist, it doesn't really count. Rather than experiencing internal states, I experience my existence as it thrusts itself in the world. Therefore, to believe that my experience doesn't count, amounts to believing that my existence doesn't count. But as long as I am alive my existence counts (Colaizzi, 1978, p. 52).

Human experience as individuals apprehend it and experience it in consciousness is the basis of phenomenology. Experience is viewed not as an internal state but as a mode of presence that is existentially significant. In phenomenology, intentionality means human existence and the world constitute a unity of involvement, with one not existing independent of the other and neither being the cause of the other, representing a co-constitutionality. As such, phenomenology reunites subject and object. Husserl's famous slogan "To the things themselves!" illustrates the human science direction to recover a sense of the pre-reflective givenness of things, and the life-world of experience within which object and subject are no longer alienated. In transcendental phenomenology, one "brackets" the world "out there" declaring the pre-suppositions of belief and experience which underlie the focus of research. As such, bracketing rejects the naive objectivity of natural science, and attempts to recover phenomena in correlation with the acts of consciousness and intentionality in which they are co-constituted.

Psychotherapeutic methods share with phenomenology a respect for individuals' experiences. A premise of a number of therapies is that it is the individual's experience and interpretations that generate crisis and resolve a crisis (Kelly, 1955, 1961; Paykel, 1976). Subjectivity, self-reference and self-interpretation are central to changing the way problems are perceived in therapy processes (Katakis, 1989), in communication theory and change through reframing (Watzlawick, Weakland & Fisch, 1974), in cognitive restructuring (Freeman, Simon, Beutler & Arkowitz, 1989) and in cognitive-emotional restructuring (Clarke, 1989; Greenberg, Rice & Elliott, 1993). The way individuals construe therapy influences its efficacy (Page, 1972) as do expectancies and credibility (Kazdin, 1979), characteristics of the subjects (Garfield, 1978), therapists (Parloff, 1978) and the therapeutic relationship (Frieswyk, 1985; Patterson, 1984). Therapies demonstrate in practice an appreciation of the lived experience in generating healing.

Phenomenology explores a phenomenon from the inside perspective. Phenomenology, as an orientation and qualitative method, embraces rather than rejects the decontextualization of experience and has a close affinity to psychotherapeutic method (Osborne, 1990). Phenomena are not in the world "out there", nor are they "in the mind". They are in experience, in the life world which is the synthesis of the two. To explore, discover and understand healing from suicidality, the human science method of phenomenology was chosen to identify and develop understanding of the phenomenon of healing from suicidality. In the return to the things themselves, a meaningful study of a phenomenon is achieved by descriptively identifying what a phenomenon is. Understanding comes with faithfully describing the phenomenon. Descriptive identification allows discovery and understanding which are the foundations of phenomenological research.

The basis of the phenomenological approach to research, and this study, is that individuals' experiences are valuable and can faithfully describe what was helpful in healing that made a difference between wanting to live or die. To identify a phenomenon, one must begin by contacting the phenomenon as individuals have experienced it. Participants were solicited and invited to tell their stories in response to the open ended question, "What was helpful in your process of healing from suicidality?" Individuals' processes and subjective experiences were accessed through dialogue, and their descriptions illuminated the phenomenon of healing.

Presuppositions

Natural science trusts its methods to eliminate bias and reveal the world in its purity. Phenomenology, as a qualitative human science method, attempts to bracket its presuppositions, to set them aside to allow the givenness of pre-reflective experience to emerge through dialogue.

Upon reflection, as researcher, I examined my basic assumptions on human nature and functioning, and on the etiology and dynamics of suicide and healing which constitute my presuppositions. First, I was not disinterested in the topic, but avowedly interested as a clinician to discover what could be learned by listening to the experience of those who had moved through suicidality and were suicidal no longer, and to understand so the learnings may be applied in therapeutic work.

A basic foreunderstanding is my belief in human nature as inherently good, pro-social and forward moving. Individuals' perceptions are valued, as is each individual's capacity for discovering the meanings of his/her own inner experiencing. Although individuals' perceptions are valued, and believed real for the individual, I recognize they are subject to distortion and defense mechanisms.

I accept 'The General Model of Suicide' proposed by Maris et al. (1992) as a generic guide to understanding the development of suicidal behaviour. This model describes the interacting context domains and factors which may lead individual's to their personal threshold of pain and a suicide zone in which suicide may occur. The psychological dynamics of suicide are understood through Shneidman's (1985, 1987) 'Ten Commonalities of Suicide' and the 'Pain, Press, Perturbation Model', and the suicidal syndromes of Miller (1967) and Breed (1978). I accept and understand the suicidal conclusion and decision described by Kelly (1961) as an adaptive validational act.

I have understood healing as dealing with the constructions and context of experience through shifts in meaning and adaptation. For suicidal individuals this is understood through Miller's (1967) model as dealing with crisis, communication and commitment. In this model crisis involves handling affect, coping with change and challenge and interpreting self/others interactions; communication refers to developing contact and expression; and commitment includes the expansion of the image of self and activities. These are the foreunderstandings and presuppositions on the etiology of suicide, healing and human nature that I brought to this work as a professional.

As a person and from my life I bring foreunderstandings and presuppositions as well. Over the years death has not been a stranger in my life. I have experienced loss through suicide deaths of a colleague, neighbours, friends and family during childhood, adolescence and adult life. These losses propelled me to seek an understanding of the reasons and dynamics of suicide. Over the years my understandings and needs have changed, shifting from understanding 'why' to the search for answers on prevention and healing. The search to understand suicide was fuelled initially by the pain of loss and later by questions on treatment.

Personally and professionally I have been touched by the overwhelming despair felt by those who are suicidal, and by the impact of suicide deaths of those for whom I cared. The despair of being suicidal and losses by suicide are tragic. I believe new avenues to prevent suicide and heal those who are suicidal are to be sought and found. I have foreunderstandings about what I believe are the needs and realities of this search. I believe treatments have been ineffective, conceptually and/or through delivery, failing to interrupt a suicidal process at best, and at worst contributing to a death by failing to protect what could have been foreseen. I do not believe in the possibility of eliminating all suicide deaths, or that treatment can reach every one who despairs. I do not believe in coercive measures, but rather in cooperative intervention. While in despair, I recognize the realization may not exist that emotional despair can heal, or that help may be available. My search is for new avenues to help, so that when a suicidal person is identified or reaches out, help may be provided that is truly helpful. My personal experience provided the energy and enthusiasm to pursue this study. My professional encounters and those with whom I work are expected to be the beneficiaries.

The Participants

The goal of research was to illuminate the process of healing from suicidality through descriptive dialogue with those who had experienced the phenomenon. Contrasting groups and diverse subjects provide a range of factual variation and encourage the full illumination of a phenomenon's structure (Wertz, 1984). Therefore, subjects were sought through advertising to draw a variety of experience and not circumscribe respondent experience through other selection methods.

Those who responded and participated in the study constitute a purposive sample of individuals who were once, but were no longer suicidal and who wished to communicate, explore and share their stories of healing. Self report of previous suicidal impulses and behaviour, along with the requirement that no attempt(s) had occurred in the past two years, served as screening criteria. For most of the participants, the time since they were suicidal was much longer, ranging from two to over twenty years.

There were nine participants, seven women and two men, from age 27 to 57. Demographic description of this group, in relation to specific suicidal descriptors, is cumbersome to try and pinpoint as the time and events described span decades. Participants experienced more than one suicidal crisis, and their healing occurred over many years with many changes. Six had experienced repeated suicidal behaviour, from childhood through adolescence to adulthood. Three had experienced suicidal crises only as adults. At the time of the study five were single and four were married. Three had divorced and one was remarried. Five had children. Four were Catholic and five Protestant. Education/occupation included clerical/technical and university educated professionals.

The participants included individuals who did not receive treatment in a formal sense or setting as well as those who did. They had all been suicidal and were no longer. Each participant was considered to be an expert on the phenomenon of healing; and the interview dialogue, an opportunity for the phenomenon to show itself.

The Procedure

Preparation for this study involved a number of tasks. The first was to review the literature on what had been helpful in healing from suicidality, and to seek out existing work on individuals' perspectives of their suicidal healing. Descriptions of outcome studies and treatments of what was helpful were reviewed in Chapter Two. Individuals' descriptions of their suicidal processes and experiences were found in clinical suicide interviews (Havens, 1990), literary work (Alvarez, 1971), biographies (Lester, 1991) and suicide notes (Leenaars, 1991). Descriptions were not found on suicidal healing by those who had been suicidal.

The next tasks were to prepare materials to solicit and screen participants, outline the study, obtain permission from participants, guide interviews, and for ethics review of the planned research. These materials are included in the appendix.

The study was in full motion when participants were solicited through an advertisement placed in the local newspaper. Respondents were initially screened and interviewed on the telephone; the purpose and nature of the research was explained along with the type and amount of involvement that was required. For those interested, a date was set for an interview. The interview format was open ended with minimal structure allowing the participant's experience to present itself as spontaneously as possible. The interview began with an open inquiry about their experience of resolving suicidality, "What was helpful in the process of healing from suicidal behaviour?"

Care was taken to establish rapport, to become immersed and to follow the participants' stories which typically began with when they were suicidal. Probes were extended for clarification and/or elaboration as required. Prompts related to specific aspects, suggested from the review of the literature, were initiated when participants came to closure on specific points they were describing. A general interview guide was prepared for guidance and reference during the interview. Each interview took approximately two hours, and was audiotaped and transcribed.

Data Analysis

Each participant's written transcription, or protocol, was read and reread to allow the researcher to acquire a feeling for the data and become immersed in the description of the life world of the participant. Each protocol was considered statement by statement with respect to its significance to the suicidal process and healing from suicide. Significant phrases, sentences or paragraphs were extracted and recorded in a tabular format. Corresponding to each significant statement in the table, a paraphrase was made for each statement in an attempt to spell out the meaning of the statement. An illustration of this process is included in the appendix (Table 7).

> Particularly in this step is the phenomenological researcher engaged in something which cannot be precisely delineated, for here he is involved in that ineffable thing known as creative insight; he must leap from what his subjects say to what they mean. This is a precarious leap because, while moving beyond the protocol statements, the meanings he arrives at and formulates should never sever all connection with the original protocols; his formulations must discover and illuminate those meanings hidden in the various contexts and horizons of the investigated phenomenon which are announced in the original protocols. (Colaizzi, 1978, p. 59).

Continuing to go beyond what was in the statement to what was given with it, the researcher allowed for the emergence of themes, which were named and recorded beside the paraphrase and significant statement in the table. The movement from surface meanings to immanent meanings required lingering and patient dwelling with many descriptive components. This process was repeated for each of the nine protocols and represents a within persons analysis.

At this point the analysis was reviewed and irrelevant descriptions which had been included were eliminated, along with repetitions. Unique items were noted, and included. The remaining theme units (significant statement, paraphrase and theme) from each participant's protocol analysis were pooled, and then sorted into groups or clusters of themes. The clusters were named, forming first order themes which were then grouped and named, forming second order themes. This process of sorting the pooled themes represents a between persons analysis.

This process was like taking a dozen decks of cards, not knowing one deck from the other, yet knowing there were decks, and that the 'cards' had meaning as do face cards and suits with their different shapes, colours and numbers. The process was one of developing awareness and then naming the shapes, colours, numbers, suits or decks. With time, reflection and patient dwelling, the hundreds of 'cards' were sorted into themes. The analysis formed levels of themes moving from particular instances to abstract meanings.

Themes were taken back to the significant statement and to the interview transcripts to validate depths of meaning of the themes, clustering of themes, and cluster grouping into higher order themes. The culminating structure of second order themes is considered to be internally cohesive, fully illuminating the phenomenon of healing from suicidality as expressed explicitly or implicity in the participants' descriptions.

The final structure of second order themes was compared to the original protocols and reflected upon to determine if each protocol exemplified the thematic structure. Questions were asked of the data: "Is there anything in the original protocols that isn't contained in the themes?" Do the themes contain anything that is not reflected in the original descriptions?" Exceptions and unique experiences were examined against the thematic structure to see how they fit, or did not fit. The thematic structure was abstracted and refined to account for all the salient descriptive data. A final validating step was taking back the thematic structure to the participants for their review.

In Chapter Four the final thematic structure is depicted in a diagram, a narrative synthesis, and an integrated description with quotations from the original protocols to illustrate the immanent meanings of the themes. A description of the phenomenon of the process of healing was arrived at, and an ending drawn, knowing that the data and thematic structure could be re-examined with ever expanding horizons. This is as true for this research as for the process of healing, for to be human is to never arrive, to always be in process and on the way.

CHAPTER FOUR

RESULTS

A Journey Away and Return to Self

> Phenomenology is the study of the structure, and the variations of structure, of the consciousness to which anything, event, or person appears. It is interested in elucidating both that which appears and the manner in which it appears, as well as in the overall structure that relates the "that which" with its mode and manner (Giorgi, 1975. p. 83).

The results of 'A Journey Away and Return to Self' are the discoveries of what was involved in the processes of becoming suicidal and healing. Individuals illuminated the phenomenon of healing and how that healing was accomplished in their everyday lives. This was achieved through description, a method that stays with the world involved human experience as it is given. This process of description and discovery included an interview and a protocol analysis which moved from specific surface meanings to deeper abstract meanings. A final thematic structure evolved through the phases of analysis illuminating the phenomenon of suicidal healing. These phases are illustrated in the appendix (Tables 7, 8 & 9).

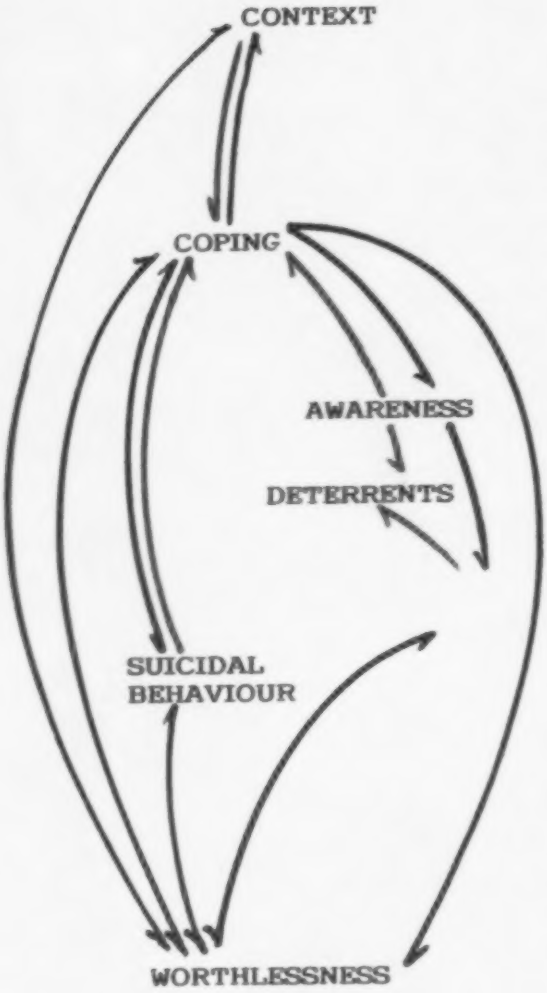
The final thematic structure is depicted in a diagram (Figures 1, 2 & 3) which presents the first and second order themes as a complex network of interconnections with movement occurring through the pathways in a recursive process. This is followed by an explication of each theme with illustrative quotations from the interviews with the nine participants. A narrative synthesis summarizes the collective experience of the participants' experiences of healing.

The diagram illustrating the themes is presented in three figures, which may be viewed independently of each other or together. Viewed independently, Figure 3 illustrates the first order themes of The Journey Away and Return to Self. Figures 1 and 2 illustrate the second order themes and the network of interconnected pathways among the themes. Pathways among themes on which movement may occur that lead toward suicidal behaviour, or healing, are illustrated in red and blue The colour blue is assigned to the pathways that describe disconnection and the participants' experiences that lead away from the self and toward suicidal behaviour. The colour red is assigned to the pathways that represent connection and the participants' experiences that lead to new patterns and honouring the self. The colours, viewed from left to right, illustrate the movement from blue pathways of disconnection, through a combination of blue and red, to red pathways of connection. The arrows illustrate the recursive nature of movement that may occur along the pathways.

Viewed together, Figures 1, 2 and 3 illustrate the interconnected patterns of movement and the complex recursive process of becoming suicidal and healing illuminated in the themes of Suicidal No Longer: A Journey Away and Return to Self.

Figure

Second Order Themes: A Journey Away


CONTEXT
COPING
AWARENESS
DETERRENTS
SUICIDAL BEHAVIOUR
WORTHLESSNESS

Figure

Second Order Themes: And Return to Self

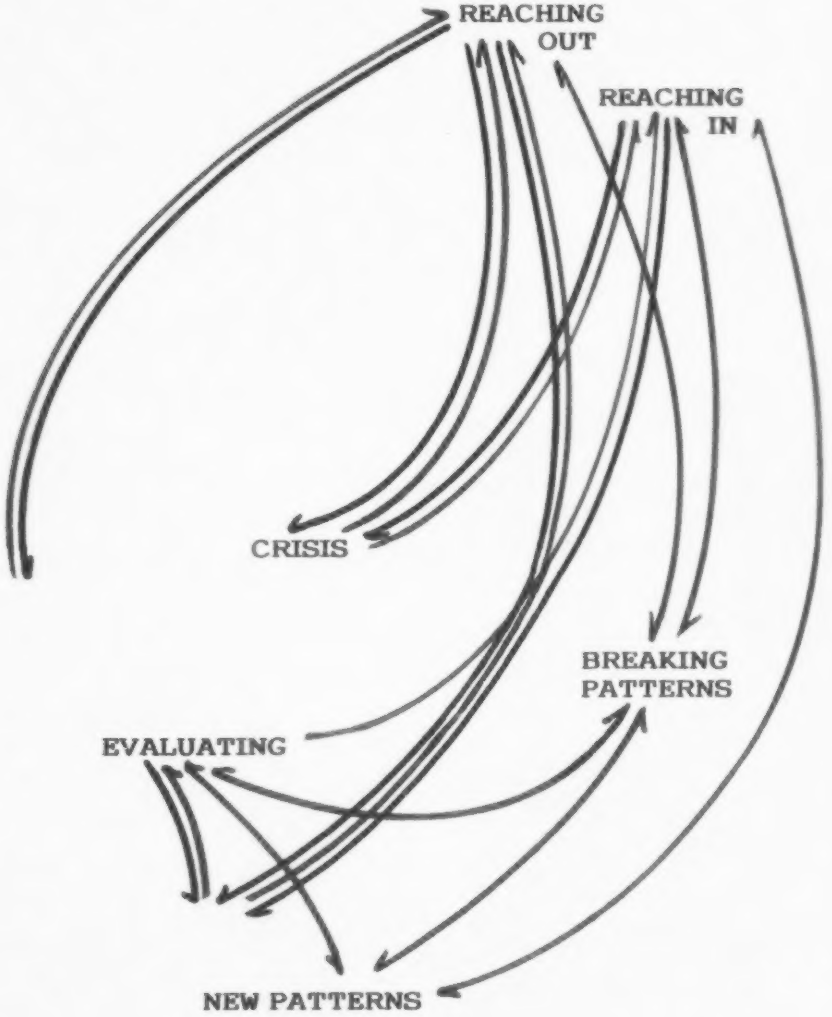

REACHING OUT
REACHING IN
CRISIS
BREAKING PATTERNS
EVALUATING
NEW PATTERNS

Figure 1, 2, 3

First and Second Order Themes: A Journey Away And Return to Self

---

connecting
experiencing support
misconnections

Learning What is Lived

Connecting With Others

loss
negative interaction
invalidation

Connecting With Self

Living What is Learned

accepting responsibility
dissociation
withdrawal
constriction
silencing
acting out

opening to feelings
connecting feelings
connecting suicidality
identifying fears
articulating anger
unfinished business
struggling with denial

listening to self
using awareness
maintaining connections
determining needs, boundaries
expressing self
receiving feedback

function
recognition

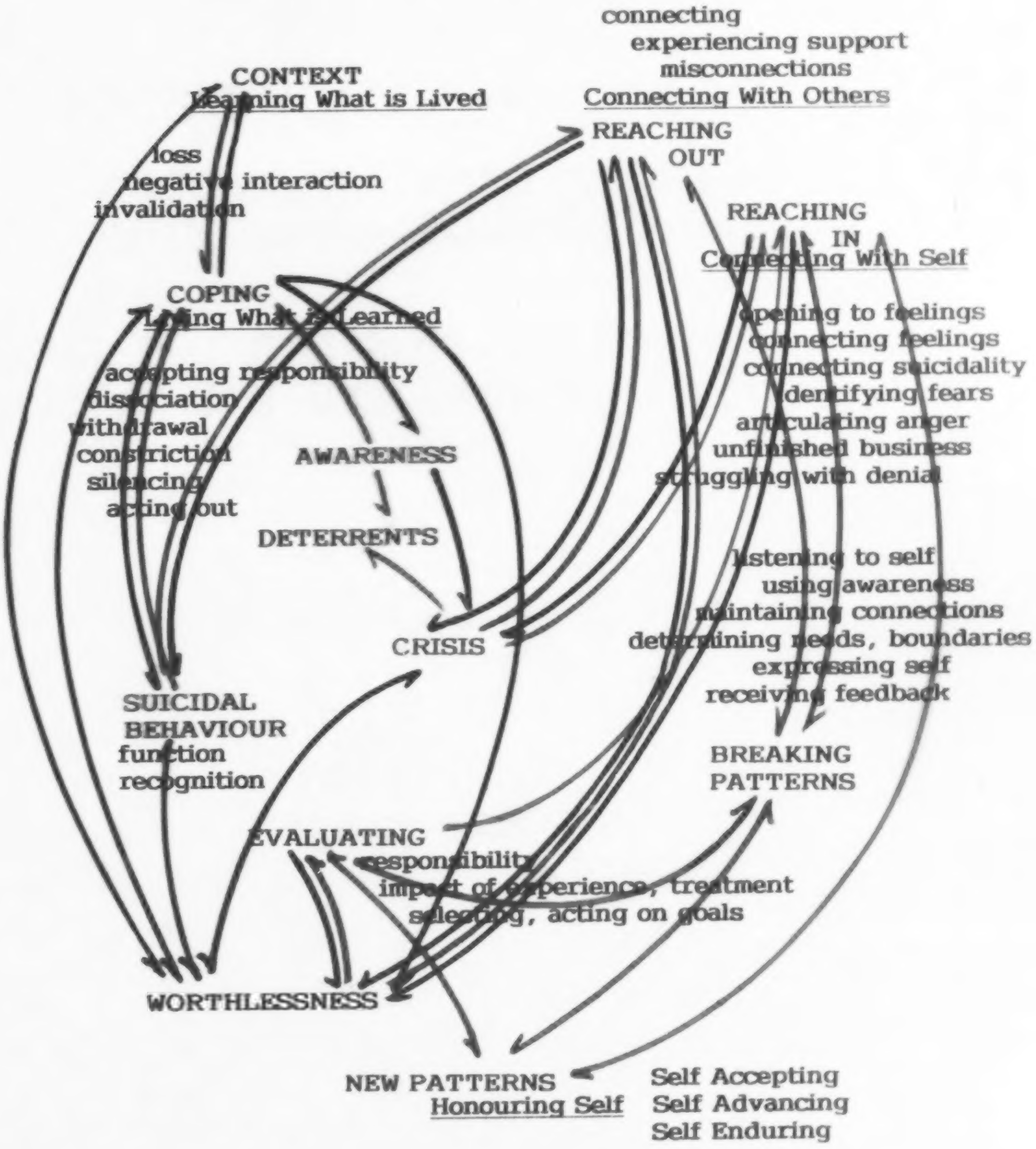
responsibility
impact of experience, treatment
selecting, acting on goals

Honouring Self

Self Accepting
Self Advancing
Self Enduring

Figure 1, 2, 3

First and Second Order Themes: A Journey Away And Return to Self


connecting
experiencing support
misconnections
Connecting With Others
REACHING OUT
CONTEXT
Learning What is Lived
loss
negative interaction
invalidation
REACHING IN
Connecting With Self
COPING
Living What is Learned
opening to feelings
connecting feelings
connecting suicidality
identifying fears
articulating anger
unfinished business
struggling with denial
accepting responsibility
dissociation
withdrawal
constriction
silencing
acting out
AWARENESS
DETERRENTS
listening to self
using awareness
maintaining connections
determining needs, boundaries
expressing self
receiving feedback
CRISIS
SUICIDAL BEHAVIOUR
function
recognition
BREAKING PATTERNS
EVALUATING
responsibility
impact of experience, treatment
selecting, acting on goals
WORTHLESSNESS
NEW PATTERNS
Honouring Self
Self Accepting
Self Advancing
Self Enduring

Explication of Themes

Journey Away From Self

Context: Learning What They Lived

Loss. Participants experienced loss and disrupted attachments through death, and emotional and/or physical separation in relation to others, goals, or health. These losses represented the inability to function in the manner in which one was accustomed, the inability to choose, thwarted choices, isolation, and a lack of structure or direction diminishing a sense of a personal future.

> You see the thing is, my Dad was in the military so we moved around a lot. I had no support growing up, my grandparents were nine hundred miles away at the closest. I had no brothers or sisters, just Mom and Dad. I was ostracized by other kids a lot of the time. I had nothing so I coped the best I could and it was abnormal.
>
> I have had warm spots or kind of ugly spots.... I had some friends going to a one room school house... we hit grade six, we broke off into different classes and they didn't associate with me any more. The fact that these people didn't talk to me any more really hurt.
>
> Nobody was there in those early years. Nobody.... I had a cat once and I got really close to it and a weasel ripped its stomach open and I had to shoot it. And, like, when I shot it I just prayed to God, you know, "Why do you give me these things that I have to kill?" You know? "Why, why does this have to be this way?" I was really attached, I played Hide and Seek with that cat.
>
> I started getting these terrible migraine headaches and they were disabilitating headaches. I didn't have a life, I had a headache. And everything had to revolve around these headaches, and I started missing time at work, and more time at work.... I was very very upset. My whole life just seemed hopeless.... I was missing days at work and not doing things that I thought should have been done and doing... things that I had set for myself, I didn't meet some of my goals that I wanted at work.
>
> My father had just died... and then I started with Dr., and of

> course I'm upset because I'd been kicked out by one psychiatrist already and I'm desperate, and also, it's September and I have to go in and drop out of school again... it was another big bunch of hope lost, you know, because I had really believed that I'd get well.
>
> I'm on antidepressants... Dr. says you have to stay on it for at least as long as you are in depression and maybe forever. He said the depression is likely to recur.... I mean, you know, like, it's, I feel like a, I feel like I have no future, I mean, the whole time I was in depression and suicidal of course there is no future.
>
> I had been having an affair with a man that was married from the town close by. It ended, and I wasn't working. I had money, I had worked in the summer.... I think I was quite bored... and then just partly the times and I guess finding out more about myself. I had decided not to go back to university and I'd gone four years prior to that. I just had one more left to go and I didn't go back.... I had gone to school from the time I was, like, four years old. I had started early.... And I just kept going... and I guess just, you know, that I was starting out my life as myself and not as part of the general family or their expectations or whatever.

Negative interactions. Interpersonal interactions were described as negative and stressful. The participants experienced physical abuse, sexual abuse, or emotional abuse in the form of criticism, blaming, denial or discounting. Several participants experienced these forms of emotional abuse from helpers during their search for help.

> I talked to my Dr. about my feelings about sex and unhappiness in the marriage. The Dr. did a pelvic exam, to check out if there was some physical problem I guess. I felt it was like another invasion of my private parts against my will. He announced I was pregnant and any discussion of my feelings about sex or marriage went out the window. It was like you've had sex, you're pregnant and this is more important that what you're feeling. It was go home, be happy, you're going to have a baby.
>
> I saw a lot of abuse, I saw a lot of people yelling at each other... my brothers punching each other until the blood come out of their lips and their eyes would be black and I would get picked on because of my size... parents fighting... the yelling stuff and withdrawing from each other, walking away in a rage. And, I remember that I always wanted out. I did not want to be in that environment.
>
> He had an affair when I was pregnant... he was supposed to end the affair. I didn't believe that he had, and I still don't know

> whether he did or not when he said he was going to, because I said, "Well I'm just going to leave if you don't end the affair. I don't need to have this sort of thing." I felt fairly strong then, but, and I thought, well I'll give it a chance... I did go down to the bar where he used to spend time that was close to his work and I was angry that he was there, because that's where the girl worked, and he dragged me out literally and beat me, like, and this was like just a little while before my son was born. And he would not hit my stomach but around my face and things like that.
>
> In the past when I tried to tell my mother, I told her about him walking around with his penis sticking straight out of his pants when she was not home. She just, "Oh, no, he must have just forgotten to zipper up before he left the bathroom." When I asked her for a lock for my door to keep my Dad out, I didn't go into why I was keeping him out or anything, but the inference of a kid was there was something going on and I was getting tired of it, "Oh, well, he won't like that, he won't like you having a lock on your door." Right, he wouldn't like.... The first, the very first time that I'm aware of this, I was laying in bed and don't know why I didn't open my eyes or anything else but my mind opened, "He's rubbing his penis against my face".... And then after that he french-kissed me, I puked all over him, and it just went on.... I ran outside the house, off the street, with him on my heels the whole way. I ran into my Mother's bedroom. She was sleeping while this was going on, and before I could get a word out of my mouth he was close enough behind me that he started saying things, "Oh, I just told her that boy she saw the other night was gay and she's all upset about it." Wasn't gay that he used, fairy, was a fairy, and she's all upset about it, and I just, what the hell is going on, and I couldn't say anything. I just burst out crying and bawled and shook. And she said to me, "Well, your Dad knows about these things." So the next time he came near me I looked at him and I said, "You touch me, I'm going to the cops." "What about your mother and what about your brothers?" I said, "They're better off without you."

Invalidation. This was experienced through direct messages and colluding or scapegoating alliances; in families, treatment or with friends. Invalidation occurred through distorted messages held by or directed to the self, power struggles, the experience of not belonging, being treated differently, feeling unloved, being blamed for others' behaviours, being publicly humiliated or punished, not being supported or protected and having one's sexuality and orientation taunted and challenged.

> I have a sister, just one sister, and my Mom treated her very much differently, she was really close to my sister and it was really obvious that, every one noticed that she treated my sister so much better than me, and that was a hard thing for me to deal with, it was really hard.... He (step father) had treated me differently too. I had always felt I was always the first one to be punished, and he was a big spanker, and I always felt that there was a big difference there.... He was real power hungry, he was a real controller and he couldn't control me and he hated it because I was always very stubborn and by then I was so much older and you can't go back to treating some one like a child.... I was eleven. They had only known each other for a weekend or something and then he moved in and they did eventually get married. It only lasted a couple months total but he made my life hell. He grounded me for the whole winter, I can't even remember why, I'm sure it was something stupid though, but I was grounded for the whole winter... and I remember it was almost like, I'd almost equate it with having, what I understand a nervous breakdown is. I would just cry. I cried and cried and cried and cried and cried until I couldn't, until the tears stopped coming out.

> She said, "Well, you know, I really wanted the first three children, but then when (participant) came around, it was nice to have a baby around again." You know. So it was right there in clear view that I was not wanted and it was hard to accept.

> I was never good enough for my parents, my aunts and uncles always told me I should be better because, first of all I was born illegitimate and my mother kept me, and second of all my father adopted me, so I had so much to be grateful for and I was such an ungrateful whelp, and I always did bad things and I always had to be punished for them.

> My mother always used to accuse me of being a homosexual, because I'd hang around with the guys, because I didn't date girls, I didn't chase girls like everybody else. And I felt like a misfit.... And I used to go crazy with that. And she'd watch me like a hawk.... I ended up in a relationship I wasn't even ready for. Most of it was just to get rid of the pressure.... And the same thing with my aunt to get rid of my virginity. Just to get it out of my life. I didn't want it.

Coping Solutions: Living What They Learned

Loss, negative interactions and invalidation formed the context and learning environment for the participants. They employed a variety of solutions and coping strategies to the struggles of living with what they had learned.

Silencing. The participants were silenced in body and voice. They suppressed, denied and were unaware of their feelings and reactions. In response to life they were unable to disclose feelings, reactions or events - illness, physical/sexual abuse, infidelity, suicidality; or to make and/or refuse requests and demands.

> I know I was sick and I know I was afraid to tell them I was sick because I thought I would get a licking for it.
>
> From November to February he was still in the house and the day before Christmas his girlfriend showed up. He had enough control over me that he talked me into letting her stay in the house...her and her kid...She stayed one night.... Well, he did his best at that time. He wouldn't move out or anything. He put the proposition to me that we could live nicely as a threesome.

Withdrawal and dissociation. These were experienced through emotional, physical and social isolation as they withdrew into self, from others, activities or the self, experiencing numbing, a sense of unreality or being 'out of the self'.

> I just withdrew, I didn't play sports, I withdrew from everything in school. During school, I'd hang out in the bathroom and just do anything to avoid people altogether. And I didn't really push myself as far as achievement. I didn't make marks.... I didn't like my teacher and I just didn't... just checked out.
>
> We got into some pretty heavy fights. And I didn't like fighting, it was almost like I was a robot.
>
> I would go and cry and hide in my room.... At the time, and I've done this a few times, my partner knew this routine, and if he didn't let me go to my room I would go away.... There. I would sit there and I would stare. I would go up there.
>
> It felt like I was having all these masks that I wore, and I didn't have one for me. It was just masks, and I felt like a shadow and I was fading away, and fading away, and fading away more, and if you put your hand on me you'd go through me. I didn't feel real, I

> didn't, didn't feel like a person. I crawled more and more within myself.

Constriction. Constriction functioned to block awareness of self, others or information. This was achieved by regulating their focus, contact and/or activities, most often by limiting it but also by expanding their focus. Regulation formed a barrier through increased or decreased activity and distraction preventing awareness of information or experience. Participants were also regulated or blocked by others.

> It's almost like an obsessive thing when you're, you know, I guess the word's sick, or have a lot of problems. I will throw myself into something, and I think that that is what it was. It don't think that my problems were solved but at the time I was totally care free. No one would even guess because I was just so wrapped up into all this. It just became my life. I never, you know. And then eventually you come down off your little cloud, you know, bit by bit and reality hits you and you realize that you haven't, that your problems haven't changed, God hasn't taken them away or anything. You just were diverted.

> I guess I looked at it that it was my fault and what I was doing at the time, was if I can't change this then I will free him so he doesn't have to sneak around and do these kinds of things.... Inside I really felt that so it didn't matter about the outside.

> I don't know what the word is, I couldn't breathe. She wouldn't let me go out, she cut off all my friends. I couldn't see my friends at any time. I tried to say, "Well, I can't, I'm going to leave, this isn't a healthy relationship, this isn't going to work." And she would threaten suicide and I didn't want to be responsible for her dying. You know, I was the one that was no good. I didn't want to be responsible for her death.

Accepting Responsibility . A strategy for survival was to accept responsibility to protect the self and others. Accepting blame and responsibility meant doing it better, and for some, accepting blame meant punishing themselves as well.

> I have to protect her, I have to keep this lie in me to protect her, and this is the kind of things that I was doing. If she'd break a dish, it was up to me to say I broke the dish and take the pressure

> for it, so she didn't have to take the pressure for it. When the boys did something wrong and I knew that they were going to get in big trouble, little things I didn't, I'd tell 'em, "You don't say anything and I'll handle this".... He was coming through the door and I had already seen one kick land on the kid, and he was in the middle of kicking and I stepped in between and got the kick, and I said, "Don't you ever, do not ever let me see you do that again." Those times I could always, and when he was beating my mother I stepped in... "Leave her alone".... When it came to me I just, I knew all the routines, so all I had to do was go, "I'm sorry." and that's good for 2 hours. What I really hated was the spit on my face, and you couldn't wipe the spit off because then he would hit you. If you reached up to go like this or something you would get hit.
>
> My husband ran around and had ran around for as long as we were married... so all that made me want to do was work harder to save this marriage, to not have him do that.... To try to make him want me all the more and be a better wife so he wouldn't want to go out and have other relationships.... I made sure I was there for him sexually. When many times when he was getting ready to go out, I would initiate sex so that he wouldn't want it when he was out because he would be satisfied. I made sure the house was kept clean and the meals were always good.... He would come home and say, "I'm having a rest before I go out tonight. Keep the children quiet." and I'd work it out to keep the children quiet. And now I look back and it was so unfair on the children cause they weren't bad noisy kids at all or anything but the minute that they did anything, "Shhh, daddy's sleeping." And it hasn't made them very close to their Dad.... I'm the woman. If I was a good enough woman he would stay with me. If you're not a good enough woman, then these things happen.

Acting out. Instead of accepting responsibility or blame, others acted out. Responsibility was redirected, misdirected or projected through anger - an 'attitude', violence towards the self, others or animals; with addictions - activity, eating, alcohol, drugs, or sexual behaviour: rejecting, violating, or seeking love/validation through sex; or by developing physical problems.

> When I was younger, for acceptance, I joined a gang. I was a bad kid.... I beat up kids, slashed tires, stole cars, you know, but it's acceptance again, looking for support, looking for acceptance, looking for security.... You know, and I'd do anything, I didn't want to be, I'd do anything to get that acceptance so I had to, and after a while I got so hard I just didn't think about it.... Yes, and

> again, all these feelings I stuffed until that night and all these feelings came up all at once.
>
> I just got rapped by my parents and the next thing I went downstairs to a dog and got him really furious.
>
> I got very promiscuous, really promiscuous, because I just felt so bad about myself, so I thought well, this is all I'm going to get, so I'll just sleep with him. It was never for the sex. I never really enjoyed it or anything but... to be loved.
>
> (During the second crisis) it moved up to my head. The stomach stopped. I was getting headaches and the allergies too. And in the time that I divorced (ex-husband), met (2nd husband), and those 8 years in between the allergies had receded and all of a sudden they were starting to come back. I was starting to get hives all over again. I was starting to swell miserably. The back of my neck gets so swollen that I can't lay on a pillow.

Worthlessness

Participants learned from their living experiences and coped to survive. What they learned was that it was hopeless and they were worthless. They felt the judgement and experience of not belonging, feeling unimportant, unlovable and unloved. They described themselves as feeling and being bad, no good, dirty, ugly and shamed by those from whom they wanted love and approval. Several participants described inside-outside splits, as either outside public / inside family behaviours, or as an outside expressed visible self compared to a silent unseen interior self. Worthlessness was attached to the inner self, when looking good on the outside, and feeling bad, meant they were wrong on the inside; that feeling bad in response to their life context (violation and invalidation) meant they were inadequate and unable to cope. Participants blamed and rejected the self for being, hurting and/or becoming what they hated, believing they deserved nothing. Several believed God had rejected them as well.

> When I was fourteen I dated a girl. She was very attractive physically, very nice personality... and she left when I was fourteen and went to another province.... And it really hurt. Like I really wanted to be with this girl and nothing happened. I just shut down.... Dissociated.... I saw myself as ugly. Really ugly. I didn't date. I didn't even go near girls, especially anyone that had any looks 'til I was twenty-three. I just didn't date at all.
>
> The struggle. I wrote about how everything that I did was wrong as I received those messages from my husband, and from my self. One page even made a list. I didn't walk right, talk right, look right, be a good enough Mom, good enough wife, good enough homemaker, spent too much money, and on and on. I wanted things from my husband that he couldn't give me, like time, attention and affection. He wanted a Barbie doll in his image that he could program, and sex. Things that I felt and believed and did, if they were not how he saw it, they were ridiculous, disgusting and plain wrong. They were to be gotten rid of. I felt putdown, inadequate, dismissed and unloved. The woman on those pages wanted to be loved back. To be loved back she accommodated but it never worked, the criticism continued anyway. She stuffed it and drank and learned not to feel.... She didn't know what would make her feel good except not to feel.
>
> I didn't understand why they didn't talk to me. I thought it was because I was a 'Mc.' I thought it was because, you know, there were double standards we were living at home.... I grew up in a Christian environment where we were role kids, people liked our family because we were a very wonderful family and they didn't see the stuff that went on there. It was like we had to wear two identities and I just, it was crazy.... I figured it was because, it was just dirty, who I was. Shame.

Awareness of Suicidality

Function/motivation.

All of the participants wanted the feelings, situation or environment to change. At various times they vacillated between wanting to die or not wanting to die. Several wanted someone to know their pain. They gave up and wanted escape through death when they experienced no one to listen or care, when they saw no options, when they couldn't negotiate demands or conflicts, when they lost the function and value they derived from looking after others or when their efforts didn't bring a change in feelings, the situation or others behaviour. One participant wanted to release or unburden others, and another to be reunited in death.

> My Grandfather died when I was about four and he was the only person I ever trusted, I was ever close to. And when he died I wanted to be with him but I didn't know how to get to him.... I remember when I was six I had Scarlet Fever and I was very ill and the doctor said, I couldn't see the doctors, but I could hear them, and they said, "If you can't get her fever down, we're going to lose her." And I thought that was grand because that meant I was going to die. I think I wanted to die all my life.
>
> I used to cross the White Mud Highway at a hundred miles an hour, and I remember going about a hundred miles an hour, it was a Honda 400 and it was red lined and all I could see was a cement pillar on 122 Street, I think it is, and I wanted to hit it. I wanted the rest of the world to see that I was in pain and drag me off the cement and have me there. Just to know that this is 'me' and he is in pain.
>
> I hated who I was, I hated what I did, I hated the fact that I violated another human being the same way I was violated and the thing that I was, I wanted to kill him. Any way at all, just end it.

Recognition. Distressing demands, situations, memories and feelings triggered death and escape thoughts and behaviours. This connection and awareness was clear for some participants and not recognized by others. Some participants recognized a life crisis, a crisis of worth, feeling, and responsibility, but not a suicidal crisis. Others were overwhelmed by suicidal impulses experienced as beyond their control and without choice. Several were shocked by the label and struggled with recognizing their behaviour as suicidal.

> She asked if I would consider going to the suicide program. And I, "What, I'm suicidal?" And she said, she described to me back, things that I was feeling, so I looked at that, and decided, yeah, that's right, and it scared me to be suicidal.
>
> Even that day I didn't recognize how suicidal I was, this was just

> something that was such an overwhelming feeling and I'm used to being in relative control of my life, and that suicide is an option.... There was no choice.... It was like I couldn't control it.... I couldn't make my head function in the right way.... This voice in my head, it was, I was aware that it wasn't me, that I was lost somewhere. It was most terrifying to not have control. My head's always worked for me.
>
> I used to wake up in the mornings saying, "I wish I was dead" and I used to pray to God that I would die, at around five years old... right up till I was eighteen.

Deterrents to Suicidality

A variety of beliefs, behaviours and events deterred suicidal actions. Among these were religious beliefs, the need to care for children, not knowing how to die and the search for the perfect plan, interruptions during suicidal acts, interventions by others, dissociation, altered perspectives and insights, shifts from helplessness to anger, the impact of suicide bereavement, and perseverance to resist powerful impulses.

> I don't know, I don't know. I just came to the edge and, I don't know. It was the same way with the tree, it's like, the time on the bridge seemed to pass and I end up not there. And I don't know.
>
> I'm not aware of what I did, because as far as I was concerned I did nothing except that I kept telling myself I had to keep taking the drugs, I had to keep seeing psychologist, of actually seeing the psychologist was good except that after paying for sessions where I had to lie on the mats on the floor and kick and scream I'd say to her, "Why am I doing this, this is not, you know, nothing is changing, nothing is changing".... One of the other things I kept telling myself, I guess that was another coping thing, I kept telling myself that I had to try, I to had try everything to get well, because I really wanted to get well and I said to her that there is nothing else left, no psychiatrist will talk to me, he would only make me take drugs and the drugs don't work and no one believes they don't work, and they say, you know, my psychologist she can't find anything wrong so, like, what else is left and I said, "I can't live like this." I fought the depression so hard the whole time and my close friend said, "You fought!" Another friend said I should do ECT.

Suicidal Behaviour

The participants engaged in a variety of suicidal behaviours during their childhood, teen years and adult lives. They experienced constant thoughts of death and perseverated with suicidal thoughts. They wished to die and prayed to die. They threatened and engaged in high risk behaviour, wagering with God about living or dying in life threatening situations. They collected plans for killing themselves; rehearsed, attempted and repeated their attempts.

> And it really floored me when he said that and I wanted to go to Dad's place, I don't know why, just had this urge, it was two o'clock in the morning, January the sixth, it was twenty below out, and I started walking and Dad lived twenty-two miles away. And I walked, probably eighteen miles and it was seven o'clock in the morning when somebody came by, it was a car, I don't know and he picked me up, and I remember I couldn't open the door handle, my hands were cold. The thing I remembered was walking in that stretch between two and seven, there were times when I was staggering all over the road, there was times when I wanted to lay down in the ditch and just go to sleep and I kept praying over and over, "If you want me to live you better give me a ride, because I don't want to live." If I make it to Dad's I'll know that it's right, something's right in my life. When I got to Dad's, I remember my hands were not frozen but I couldn't move them and he put them in water, put my feet in water and brother called up and he said, "I just woke up and I was just wondering if he made it last night?" And Dad said, "He's actually just walked in the door." And he said, "What?" And that's when I realized seven hours had just, five hours had just gone by. That it was seven o'clock and I figured that for me to be alive there's got to be some reason to live.

Returning to Self

Crisis

Suicidal crises were experienced in numerous ways with a variety of outcomes. Some experienced a singular crisis which was a pivotal turning point in their return to self and for others there were many crises on that journey. For some, crisis triggered an automatic impulse to survive, and life went on with physical realities pushing them into living. Others, without direction, a new perspective or information, simply continued; all the while feeling helpless and hopeless. Alternatively, crises stimulated a search to make the best of living, to find other solutions, information, help for understanding or resolve, or it produced internal shifts: that they did not have to die to release others or escape, and they claimed the right to live and their abandoned, devalued self.

> I guess I really haven't tried (to kill myself), I was just too discouraged to do anything. I just was, when everything went black grey, black and on from grey black, I went back to myself and I said "No, I can't." For which reason, why should you kill another person or why should you kill yourself. It's no, you have to live with what you have at the moment... there was such strong feelings that I didn't do that. I went through all kinds of periods, wasn't eating right, wasn't right, but I say no, I have to, I struggle maybe too hard, but I have no other knowledge about those things. I have many other books and everything. One tells me yes, I am just wonderful but on the other hand I am living this life, so, that's not what I wanted. So, how to make it better for my life.
>
> In the dark of one night, in the ruminations about what I could do about this, it was actually what I could not do about my life, there was no way out, things could not change, there was nothing to change.... The thoughts were about how he would never approve of me, nothing would ever please him. I gave up trying. It was somewhere in the midst of how I could hook up the exhaust that I realized what I was doing. The realization I had was that I was in the midst of killing myself. I realized that I was doing this because he didn't approve of me, that his opinion and right to life were more valid than my own, that he had a right to live and that I didn't because he was right and I was wrong. Wrong according to whom? Him! It seems incredible in this moment of telling, the thinking I had, and the power of the realization in the darkness of that moment. It became very simple. Like hell he has more of a right to live and be than I! If he doesn't like it, tough. This became the dawn of a new day, a new era for me.

Reaching Out: Connecting to Others

Connecting. Depending on the nature of the crisis, there was a new reaching out, or in some cases a reaching back to those with whom they became involved during the crisis. For a number of participants, contact marked the beginning of self disclosure and establishing emotional connections: with a partner, siblings, parents, step-parents, children, friends, activities, groups or a professional helper.

> And I went from there to openly admitting to my friends that he was running around and saying I didn't care.

> What started me in therapy, I was really angry at (partner) for something. I had gone to the dentist in the morning and I had a chiropractor's appointment in the afternoon, and I walked out of the dentist's and he was supposed to be there to drive me back and he wasn't there, and it was like I couldn't count on him for anything and it was, if I can't count on him there's no sense having him around, so by the time I took a bus... to my chiropractic appointment, I was so upset and so tense and so everything that when he walked in and said "Hi, how are you today?" I just burst.... The headaches had been here for the ten months I had been to the hospital already. The headaches at this point were coming back again, and I just, everything just burst, so he talked to me, I was a mess for about an hour. And he said, "Look, I know this person. Would you go and see her?"

Experiencing support. As participants connected with others they discovered they were not alone. Involvement and sharing with others helped them to move away from suicidal thoughts and behaviour. Support was experienced in a variety of ways when others respected their experience and listened, dialogued, encouraged safety, self exploration, understanding and further help seeking. Support was also experienced when their supportive others drew limits, held them accountable and wouldn't let them withdraw. Deeper levels of connection and support were experienced when participants felt sufficient safety to risk, explore and confront differences, anger, old wounds and abusers. Participants also drew support and comfort from pets, nature, passages such as the 23rd

Psalm and self help activities: reading, journalling, visualizing and workshops.

> I had access to some quite strong, I guess, tranquillizers...and so I just took them and went off for a walk in the woods and it was to one of my favourite spots... I guess to die.... Towards the evening I woke up.... I woke up and, I think, because you are so drugged, that you forget what actually you've done, you know... I'd woke up thinking, you know, not even thinking I was close to death or anything like that.... I walked back to our cabin... and it was very difficult to walk because, I guess, valium is like a muscle relaxant... it was really hard to keep walking, to stand upright was difficult so I kept falling backwards.... I got fairly close to the cabin and they realized where I was because they'd been looking, I guess, all day and had found the empty pills. I don't recall much of that really, little bits... she was looking frantically... they called and got an ambulance and took me to the hospital.... I was in the hospital, I think, for about a week and had quite a good doctor and good care. I still felt, I think, suicidal... my sister would come down to visit and talk, and she said, "Well, if the doctor thinks you should see a psychiatrist, then we should go." The Dr. was pretty good.... I went to that psychiatrist once, it was such a long trip, and I found her quite abrupt, even though she was known to be a good psychiatrist, but she just didn't get to me I guess... but just talking it over with (sister and brother in law), and they understood... and they were able to talk to me. So I went through it well, it was, I mean, it was probably an ideal way to weather a suicide because I have talked to other people since then who have attempted and they just didn't have family support. I mean, to me this was as a good as having family support.

Misconnections. Participants sought help and connections were not established for a variety of reasons. They thought they and/or their difficulties were dismissed by the helper; they were terminated when they challenged the helper; they felt patronized, not valued or invisible believing they were not heard or understood. They thought they were blamed, treated perfunctorily, given inappropriate treatment, or that the helper had more problems than they did. Some participants felt an emotional void even within a context of caring contacts with others.

> One I talked to about my unhappiness and not liking sex. He instructed me to draw up a scale to measure my anxiety in relation to

> viewing a male body, clothed, naked, at a distance, closer, and certain body parts. I understand this now as desensitizing to a phobia. This encounter fills me with anger as I look back on it.... I could not have labelled it then, I had no idea really but I can say that this Dr. had no idea of what was going on with me, and absolutely no idea of women, nor did he make any effort to find out.
>
> So the doctor said, "Well, how about I send you to a psychiatrist." I said, "Fine, maybe he'll talk to me." I went in there and he said "Describe your life?" And he said, "Well, you're coping really well considering all you've got on your plate. I don't see a problem here." And he sent me home. He said, "I have patients with problems."
>
> There's a tremendous antagonism between the medical profession and the psychological profession... this huge split... now, no one said this to me, but the fact that they don't talk to each other... so it's like I should go and take off my head and park it in the psychiatrist's office, you know, because he is only going to give it drugs and he is not going to talk to me, and then the rest of it is, "Oh, your body's fine." And that split I find so damaging... I was not addressed as a person.

Reaching In: Connecting With the Self

Opening to feelings. Over and over participants reiterated their struggle with the fear of feeling and feelings. They discovered the need to feel; and opening themselves to feelings they recognized, identified, acknowledged and accepted their feelings. They learned to distinguish between thought, feeling and action; and they experimented with ways to respond to their feelings.

> I wanted to feel.... I was dissociated.... I could connect with the head stuff but I still couldn't feel.... I couldn't connect with it, I went there because I was ready to die, I didn't want anything to do with life, after ten months I learned what dissociation looked like. I learned how I checked out.
>
> As you probably know, I don't know if you know, but a sexual offender looks at a victim as an object. And usually what happens, they don't deal with their own feelings, they look at dealing with the victim's feelings. You see, so up until, I wasn't dealing with my feelings yet, I wasn't exploring, I had them hidden like. I was still,

> there was so much pain I was afraid to look at it. I was afraid to get down there and feel it.... I'd have to deal with my parents, with physical sexual abuse, the alcohol, and I just couldn't do it. It was just too painful.... I felt so much guilt, I felt so much pain. I was getting suicidal thoughts again.... I was charged.... I was sentenced with the recommendation of the program.... I didn't go in right away and start dealing with it, it was hard. I wanted to but I was scared to get into the emotion.... Then I looked in and I felt like I had my chest ripped out it was so painful. It was really incredible.... I think the key, the biggest thing that the group gave me was I opened up my feelings to myself and I had empathy feelings to the person. That was the whole key. It started the whole process.

Connecting Feeling to Experience

Experiencing feeling. Participants described how they learned to feel their feelings, what feelings were, and how they were connected to experience. Therapy, workshop experiential exercises and life encounters delivered long suppressed and denied experience in feeling and meaning. One participant experienced the release of stored feelings and memories through massage. Secrets surfaced and childhood sexual abuse and its impact were unmasked, along with other issues that interfered with daily living. To feel brought incredible pain. The pain that had been pushed away was brought into awareness; it was felt and faced, and new ways were learned to deal with it.

> I was dating a girl and we french kissed. And I told her, "I said I'm not really comfortable with it but I'll try it." And we did and my stomach just turned in a knot. I didn't know what happened and I went through fear and worry, something I said, did.... Most of all that turning in my stomach, my diaphragm flipped. It just flipped. It just like, if you can imagine being sick to your stomach, immediately, right now, it was like that strong a feeling, like something was not right. It snapped.... We used to kiss before going to bed at night, we just did, never requested it, but this one night Dad thought he was funny, he stuck his tongue in my mouth. And I didn't like it, like I really felt dirty. Just 'eww', and I really remember it right now. And I pulled back and I started crying, and he said, "Come here, I won't do it again." And I did. And this time

he stuck his tongue in my mouth and put his hand around the back of my head and pulled my head in. And it was like, his tongue was in my mouth, I felt like I wanted to bite it, but I couldn't bite it because it was my father and I wrestled and pulled until I could get away from him and that's when he pushed me away and called me a little, I can't remember what he called me, like a wimp, little baby, I think he called me a baby, and asked me why I was crying and he gave me a slap and he put his foot on my ass and shoved me towards the bedroom and said, "Go to bed. Just get out of here." And I did. And I remember in a workshop I was on, that I recalled, when we did some inner-child work and I was laying on that bed and staring at the wall, hating life, wanting to die, and wondering what I'd done. Why, you know? Like I really wanted to hurt him.... I haven't really called him on that behaviour yet, but I have told him, you know, there's some things that have really made me angry about you. And, it's caused a lot of problems in relationships. I was with this girl for seven years and couldn't french kiss her. She'd get close to me and I'd, I never even knew why, but I would just get so angry at her, I'd probably give her a look like I could actually kill her, and not realizing anything about it.

I had my stomach massaged and had a memory come up about, great hate, the bully who used to punch me in the stomach when I'd come out of the bathroom, he'd used to get a big laugh out of it because I wouldn't flinch. It didn't hurt. I'd go out into a corner and gasp for air, but it didn't hurt, I was tough. And when she massaged my stomach, it was like these cloud bursts came. And I didn't know where it come from and I said to the masseuse, go back and hit that again. She did and I just told her what was happening. The muscles, the old memories.

They had a regression therapy session and you tried to go back, well when I went back I could see myself as being a little baby in a crib and afraid to cry or do anything because I would be hurt, you know, you'd be, they'd have a baby here and you are being looked after and what not. And my thing was that I was going to protect this baby so it didn't get killed and then it started, you know all my life I'd been doing that, trying to protect myself, and then the next minute I'd want to kill myself and like I couldn't understand it. And then they started working on the decision therapy and that's what got me turned around. Was I had to go back at some point, I don't know at what point but I had to go back to re-decide that I did not want to die and I did not want to kill myself because all my life I really wanted to die and I really thought I wanted to kill myself. Well, all I can remember was, of course I started crying, and crying and crying and thinking you know, like I won't, at times I thought they would kill me and then, you know, I'd fight, I didn't want to die. But then when things would happen to me then I'd want to die and so I had to just go back in my mind and think, you know, they can't hurt me any more. Like, there's nothing they can do to hurt

> me.... My parents. There's nothing they can do. I'm grown up, you know. They can't hurt me any more and I don't need to kill myself. It was like I needed to kill myself to get out of these situations or to get out of something that was hurting me.
>
> I'm a survivor. I'm one of the, they call fortunate ones. I'm very grateful for coming through it. I always say, I don't tell new people coming into their feelings, I don't tell them this. But after they have been in for awhile, they go through their pain I tell them point blank, "If I knew what I had to go through, the day I quit, I wouldn't have. It's been that painful."

Making connections. Participants discovered their feelings were connected to what they had lived and how they had experienced and coped with living. They recognized their feelings were connected to events, thoughts, behaviour and reactions forming patterns. They discovered a variety of patterns: a familiar comfort with the 'bad' and discomfort with the 'good' as bad things follow, that they didn't have healthy defenses or boundaries and that they had silent and assumed expectations. They recognized they had unmet expectations and an inability to communicate and negotiate their needs and requests, that they judged as harshly as they believed they were judged, that they used anger as a way of coping and survived pushing problems onto others. They saw that anger and their reactive 'no' blocked help, resolution and having their needs met. Participants also discovered their patterns of avoiding contact and connecting, with others or their feelings. They recognized their use of activity to distract or numb their feelings and emotional wounds, their use of constriction and isolation to avoid being emotionally wounded and their use of self abuse and punishment to reduce anxiety and restore the familiar feeling and comfort with the 'bad.'

> See, I found, I got, actually just recently I got an insight into my anger and a lot of my root emotions... it was a betrayal sort of thing.

> I'm getting better, I'm working through it, but you see this is the thing I found out, that all my anger stuff goes back to my childhood. Whenever I feel insecure, somebody lets me down, I feel I have a commitment and they don't fulfil it, the anger and the hurt come out. That was a sure relationship I had but, as I said the lapses (responses to betrayal) are getting better. But I haven't been suicidal for a long time. I'm feeling better. I'm feeling more confident.
>
> I learned what was important to me, a little at a time by noticing what was important, in the moment. I learned to listen and trust myself. And as important, I learned to say that out loud. It was learning emotional honesty.... I guess one thing I've learned over the years is the part that I played in making my own pain. I had waited for my husband to make it right for me, rather than learning to do it for myself, and.... I guess that is what he was doing too. He was trying to shape me into the kind of wife he thought a wife should be... and that I wasn't. Both of us having some idea of what we thought the other and ourselves should be and finding misery in its place because the other didn't do it right. And we couldn't, didn't know how or what was going on to do it differently. We ran aground on the differences, and our own images of what we wanted without knowing how to share or communicate that to each other.
>
> I carried a (self) abusive personality that invited people, it was like carrying a sign saying come and get me. People recognized that I could be used and dominated and hit on, didn't have any defenses, didn't have any boundaries,
>
> I was scared, I was angry at myself for feeling like this, I was self abusive at the time. I started to become very self abusive.... Bit myself, punched myself, hit myself, stood in the mirror, slapped my face, and then I'd go "You stupid puke of God". And I reasoned I was puke of God because if I was diarrhoea of God at least I would have gone through the system, but puke wouldn't even go through the system. First it started out I was diarrhoea of God, I was shit of God, then I was diarrhoea of God, then I was puke of God cause he wouldn't want me in the system.

Connecting suicidality. Participants learned to recognize their feelings and to understand that their feelings were associated with events and issues, typically historical, which then triggered suicidal thoughts and behaviour.

> Well, they (suicidal thoughts) were only there when something happens. Like, they were not always there. Just if something goes wrong I seem to be so ready to throw my life away; at least I was.

> You know, the least little thing, "I don't need this, I don't need any more." And I'm ready to go out and smash into an embankment or something, do something, you know...
>
> Rotten episode, same thing. Bang, I was back into it again. For a week, I was in nothing but feelings, anxiety, and all the crazy stuff of helplessness, and out of control. And that's when I, the doctor told me, you're not leaving this hospital until you have a sense of control. And I remember him saying that, it was just like thunder. And I said, "The only thing I feel is I feel hungry." And he said, "That's a good sign".... And to feel is to feel all feelings and I judged feelings. Shut them right down. Iced them, axed them, do whatever I had to do. Spend money, or drive fast on a motor cycle. Or have an out, to be able to look off the bridge and say I don't have to feel. I look at it now in a constructive way. Back then it was like, I had nothing to live for.

Identifying fears. Participants came to identify their fears born out of coping with the context of losses, negative interaction, invalidation and feelings of worthlessness. They identified fears of abandonment, and fears of attachment and closeness. They feared vulnerability and being violated, not being heard and not having their needs met. They feared emotional dependence, becoming powerless and losing control through their need to be loved. They feared acknowledging their own behaviour and revealing the self and doubted their ability to live up to others expectations. They feared future losses, illness and their potential for violence. At one time, for most participants, their fears had motivated coping strategies which were not helpful and led to suicidal crisis. At other times, the fear of losses was a helpful motivator.

> (2nd husband) has this thing, he goes out and gets lost. He'll drive (daughter) to work and he won't be home for two or three hours. When (daughter) was living in apartments, he'd drive her home at 11, 12 o'clock at night and not turn up here until 2 or 3 in the morning, and that just had me frantic.... I kept telling him that I can't handle this. At one point I said I can't handle this any more, and you're either going to have to stop or leave.... I was just a nervous wreck. By the time he walked in the house and I'd hear the key in the door, it would go, all these things it had built up to,

> identifying the body and everything. It would go. He's just late. He's just been screwing around. And also it would cross my mind, was he really screwing around out there? I confronted him, was there somebody else? Is there another girl? Is there another guy? Is there prostitutes? Like, I went through this cycle with him. I always believed him when he said no. And I kept digging, digging, why do you do this?
>
> We're working on the relationship now to get to know each other. It's very difficult to let this person know me. Very difficult....(in the past) as soon as I opened up anything, about being in an abusive relationship, about me being the abuser the woman would leave immediately.... When I wasn't feeling any pain around them, I was feeling like I'm a wonderful person. Like get to know and trust me, almost prostituting myself so people would like me and it would just drive them away. And I had that big secret that I had to conceal... I even sat down at the Pizza Hut and talked to her about it. I was raw all week. Really, really raw. It was a big fear, that, what if she doesn't like me now. What if she withdraws. Big panic. And I had thoughts of suicide. You know I've had it, like, it just comes in a snap.
>
> I think the big thing for me is, I'm secure, I have enough, two or three people that I trust enough that I can say anything, like totally and I know I'm not going to be rejected. That they are going to care for me so, you see now, this is a help but it is also motivation. If I reoffend I lose that all, I lose everything, I lose the church, I lose my family, I lose my friends, I lose everything I was looking for.

Unfinished business. Participants clarified their unfinished business; their unmet needs, expectations and requests of their partner, mother, father or family. They clarified their need to be heard and be understood, and to clear emotional baggage.

> She knows of them but she doesn't acknowledge them. She didn't know at the time but she won't, she doesn't acknowledge it and I think it's just hard for her. Whether, I don't know, I guess I can't say for her but I would guess she probably feels responsible and if she admits that happened then she would have to admit that she had made mistakes and she can't do that for me.
>
> When you are going through so much emotionally and then to have that rape sort of shook things up a bit, I really didn't think I had recovered from the divorce itself let alone the other dumb things that had happened.... And I moved back for a year because I thought my parents and the family there might be supportive.... I don't think it

> was abnormal all of my reactions, but I really handled myself with care and really tried to, you know, work through that... like my family was trying to slot me into that and.... And no way, if there's something wrong its not me, you know... it was quite ferocious though because there's no way I could have fit into that, so there would have had to be a lot of stormy moments.... I moved away... they just couldn't understand the rape thing at all I don't think. The divorce, well, its still, I mean they think marriage is it. And, also, I just think, you know, over a lot of things about our childhood or whatever, the way we were treated like. My mother just couldn't understand we'd be there and not doing what she thought we should be doing and just wouldn't accept it at all. But then you know, our family wasn't a happy one so I wanted to escape. I mean, I didn't feel it was happy and... we were sort of their scapegoats and I didn't like that feeling but I didn't know what it was until way later in life.
>
> It's like, I went down there expecting, about two years ago I went down expecting to heal some old stuff with Dad. I expected him to sit in a chair and talk with me. And you know, his first response, as soon as I walked into the door, like thirty-eight hundred miles and, "Well I'm going to go down and file some saws. Come on down with me. I'll file them and you come down and talk to me while I'm down there." "Dad, I'm on holidays. If you want to work, work. If you want to sit, sit." I sat there for five days and he didn't sit and talk.... "If I don't talk to this guy, I may never see him again, I may die." And he's seventy-three years old this year. And, we talked a little bit, opened up some stuff... I'm going there in July, twenty-second. And this time I'm going to confront him with some things that have happened in my life and has made me extremely raged, the distance, not trusting, and most of all, not getting ahead in life. Not blaming, just saying that this has happened. And I'm stopping this generation of it happening again.... I'd like to hear, "I'm sorry" .... It's like I'd like to hear the, "I'm sorry." But I would have to go through the other stuff.... Because I might go to that space that's...

Articulating anger. Recognizing their feelings, expressed in the meaning of their fears and unfinished business, they confronted their anger. Articulating and hearing their own anger was difficult and resurfaced old fears and coping strategies. Holding their feelings, particularly anger, and keeping them clear was an important shift in countering worthlessness. Anger was expressed towards abusers for abusing and not protecting, towards the self for lacking self trust. Anger was also expressed towards professionals for not caring and treating them as if they were invisible and incompetent, denying their experience and feelings and imposing their own. They were angry for the perfunctory treatment, the humiliating treatment effects and the stigma of depression and suicidality. They were angry at God for the 'bad' stuff: for being abandoned in their life situation, for taking away something they loved and for not allowing death.

> He was, I guess if he would have said "Yes I knew about you." or, but I could genuinely tell that this man had no recollection of me or going after my Mom. He just must of been so into the drug that, and so, you know, granted I pushed, I just took all the anger, because when I first found out, I mean I was angry at my Mom because she was the adult in the relationship and she was the one that chose to keep me, I've always wished that she would have given me up, I think I would have been much better off if she would have.... And she still won't acknowledge it, and I think that if she would I wouldn't be having as much anger towards her, I think if she would acknowledge it and say, "Yes, I did treat you differently." But she is in total denial. You know you can't force someone to see something they don't want to.... I would never let her hurt me like that again. I would never let her be in the position where she could control me.

> And each day, as the hope grew stronger, I found simultaneously that I was experiencing a tremendous shame and humiliation because I had gone out in the public for that whole time, because I had exposed myself.... I realized that I was even worse than I'd thought and at the same time I was feeling anger and it's really like rage towards the medical profession, for lying. "Oh, there's no such thing as depression, you're mourning the loss of your child bearing years." For not facing it. For dismissing it as, you know, you're mourning the loss of your child bearing years, for not having the balls to say, "I don't know."

> I really don't believe in God, I really don't know that I do, because I really very much felt alone and why would He let me keep on doing that, why would He, you know, that whole kind of thing, why would He leave me there to be so desperate. I mean for an eleven year old to do that!

Struggling with denial. Participants fought with bringing their experience to awareness. They couldn't face their own behaviour and struggled with their denial, to themselves and to others, of their feelings and behaviours, wanting to forget or avoid facing their painful feelings, history and/or behaviour.

> And the next two I don't even really remember, I just know that I took pills, but I never, from what I'm able to think back to, I've just blocked a lot of things out, I don't remember them vividly. I remember, I don't remember trigger incidents, or anything like that. I think I kind of, I don't want to deal with it almost.

> Well, today, I still have days where I would like to take a needle and blast as much drug, I don't care what it is.... I still have those thoughts today.

> Sometimes I want to just say forget it but I know that's the worst, because if I deny it and don't work with it it's going to happen again. So, I can't.

Breaking Patterns

The movement from coping the old way to coping in new ways emerged in the participants' descriptions of their paths to recovery. This was not described as a linear process nor was it always with conscious awareness. An important part of breaking patterns was the struggle to bring to awareness knowledge of themselves and their behaviour and then deliberately, with effort and fear, owning and holding their feelings and the understandings they gained, and acting on them.

Listening to self. Participants described how they learned to go with and process their feelings; to acknowledge, monitor and identify their feelings. A variety of strategies such as journalling, visualizing and dialoguing were utilized to become aware of and process their feelings. They learned to listen and to respect their fears and needs for safety.

> Because I go through a lapse and I have to monitor myself, I stay away...because of my cues.

> And she always knows the right thing to say, so I talk to her in my mind.
>
> And I do the dialogue stuff when I'm in a crisis. "So, you're really hurting, huh? Yeah. I'm really hurting, man. Shotgun's in the corner." Like I don't have a gun or anything, but you know. Visualizing this thing and, "Well, what are you in pain about?"
>
> I'm just piling it up and getting, you know, just get out and I go to that space and sometimes I just paralyse on the bed. You know, I paralyse out or on the couch or sometimes I just go flat eagle on the floor. And I don't know what clicks, just something clicks and I come up out of it.... sometimes I am able to connect with that little boy that's inside, bring him out, let him have his say.... I grab my teddy bear.... Just drop off the planet and stay there for a while.... Go into a little cocoon... eventually, I pick myself up and don't go spending money or nothing, just go for a simple walk, little drive, because I don't trust, I just drive or walk.

Using Awareness. Participants developed and then utilized their awareness of their feeling and behaviour patterns to focus on the underlying meanings, direct self care and resolve issues. They moved away from suicidality as they developed awareness of their own processes, and processed what was happening for them. Several learned to do this with a therapist's help and then on their own, using a variety of cues to remind themselves of what they needed to do.

> My type of personality is, there's two people on the street, me and another person, we both walk out at seven o'clock in the morning, both got flat tires, and we look at each other and go back into the house. My neighbour goes in, gets on the phone, calls AMA, "I've got a flat tire, please come down and fix it." I just call suicide prevention. You know, I'm just going to die. I've got a flat tire. Something happens and my life is screwed. You know, and that's the thought process, it just kicks in, bang, negative, negative, negative. Rotten, worry.... Well I've got a chart on my fridge and it's got the worst case scenarios, hopeless, worthless feelings spiralling down. On the other side of it, I've got lots of trust, hope, its peaceful, loving world I'm living in. And at the top, there's joy, happiness and courage. At the bottom, there's depression and guilt and shame. You know, I've got that. It's a very powerful tool. That's got me through more stuff lately, to just keep a positive, strong attitude, you know. I go back to it and I go, "Where am I?" And I go through the process.

Maintaining connections. Also important in this process of breaking and establishing new patterns was learning to stay present; to remain open and connected to themselves, others, activities and information. To do this they confronted their own and others' silence, secrets and denial which required revealing themselves and practising emotional honesty.

> So he had run into this a few times when things had gotten too much for me to handle, I just left and one of the things that (counsellor) told him was that I wasn't to be allowed to leave. So he did not allow me to leave. He would follow me into the bedroom and nag at me. "You've got to come and face it. You've got to come. Listen. I'm not saying you're a bad person, what I'm saying is, you didn't water the plants. That's not being a bad evil person." Anything that happened I was an wicked evil person.
>
> The only, now she knows everything, but I didn't really start opening up to her until I was in the hospital.... I, I saw guys become honest with their wives and they were divorced and I knew sooner or later I was going to get discharged, and sooner or later I had to get on with my life and I just made the decision, I was scared to death... I made the decision that if we started over again, I didn't want any skeletons in the closet... if I had any future with her I didn't want any more secrets because secrets hurt, and I said, "No more." I'd come clean, if she wants me back fine, if not then I'll just go on with my life, and that's that. As it turns out, she, we're together.... When she came in, it was quite emotional, she was angry, and sometime in my visit she would just sit there and she would yell, scream and swear and call me a child molester but she needed to vent that anger... I kind of looked at it as punishment I deserved at the time. So she raged through it.
>
> When my mother was visiting and we were talking about this and (husband) came in the room, ...or was wandering about, my mother tried to go, `Shh, shh,' and I said, `No, everyone in this household knows what went on,' and it was talked about freely, it's talked about freely in the house that I am in suicide counselling, it's not the S word anymore, it's a suicide program.... Everything is open, honest.

Determining needs and boundaries. Within this process participants distinguished the 'self' and its needs from others': siblings, parents, family or spouse. They refused choices made for them by others and/or to be abused.

> What it ended up is, he wrote me a contract out that he, first he wanted me to remind him all the time. I said, "Look, I can't do that, I'm not your mother, I'm your wife".... I did not want to be put into a position where I was having control over him. But at the same time I needed him to exert his own control... Now he'll phone me to say, "I'm really tired. I can't drive anymore. I'm going to rest for an hour or so." And then when he wakes up, he'll say, he'll phone me again and say, "I'm on my way now."... It's still not comfortable because I worry sick, but by keeping in touch and knowing that he's safe, it's not comfortable but it's acceptable enough.

Expressing self. They learned to express their feelings, needs and boundaries, to make and refuse requests, and to negotiate. They practised meaningful communication, expressing directly in terms of 'I' statements rather than blaming 'you' statements. They learned to own, explore and confront their their feelings and needs, and to express appreciation.

> And I only have to watch out that I was not badly treated verbally, nor anything else from employers. I was looking, I was very ambitious, not to be dependent, not to be dependent on other people.... That was the most important thing, yes. And I could say what I wanted to say, and I could express feelings, so. I just went over those barriers and said no, I have to say what I want to say.... I was drinking and I said, "I could kill all those feelings that I have bottled up." I started to drink. I did it only for a very short time, and I said, "No, that's not for you." That drinking is not for me. I was just so very ill and other friends, I met other friends, they were looking very well after me and I said "No, I don't have to do this. Drink everyday".... that is very dreadful to be in that situation. I have to say goodbye to him, there was no, we could not work things out and it was only, I was at fault, "You, you, you." and that was it. I went to counselling when I was, it was just fault finding and blaming, fault finding and blaming, I said no to the situation, I cannot stand, I won't tolerate... I could not tolerate it any more. I said goodbye, that's it.

Receiving feedback. As they became open to themselves and able to send messages they also opened to receive messages. They experienced validation from others when they were affirmed in their struggle and coping and when their feelings and experiences were supported, particularly their conflicted feelings and experience. They felt valued, attended to and believed in, rather than judged, criticized and worthless.

> I said "OK, I'll try again." So I went to the psychologist, and I said "I'm here, I'm very, I have lots of trepidation about this because," and I told her my past experiences, three different times, not just one, three different times... and she listened to me, and half way through the session she says, "Were you abused as a child?" Well, yeah, but that doesn't count, I'm here now... so, we talked about that.... She actually listened and actually said, "OK, I'm here to listen. You have a problem".... And it was the first time that there was anybody there for me at all in this lifetime.... And it felt like I was talking ten miles a minute trying to get everything out in case it never happened again. So the first time I was there I was just all over myself with going all sorts of places, there was absolutely no train to this thing, there was just clumps all over.... It was the first time that anybody ever had given me affirmation that I was never good enough.

Evaluating

At one point, all of the participants evaluated their lives, self and situation as helpless, hopeless and worthless. This was the lens and automatic response to feeling, particularly 'bad' feelings. As they allowed themselves to feel, and followed their feelings through events, they discovered new parameters for evaluating their feelings and experience.

Responsibility. They learned to determine responsibility as belonging to themselves or others. They began to accept responsibility for the self and their own feelings, behaviours and actions; and reject their own or others unrealistic expectations, false blame and inappropriate invitations for responsibility.

> My letter to his parents went something like "Don't blame him, it's not his fault...if I had of been a better wife." To my parents virtually the same kind of things. The letter to him was "I'm sorry I haven't been a better wife, and that you feel that you need to do these things." I guess I looked at it that it was my fault and what I was doing at the time, was if I can't change this then I will free him so he doesn't have to sneak around and do these kinds of things.... Inside I really felt that so it didn't matter about the outside...I just

> crashed. Then like I said, it wasn't suicide so much as murder because it was, if I was out of his way everybody else would have a nicer life.... And then I just thought "You son-of-a-bitch. I was willing to do this for you." Well maybe I started having second thoughts then.... I was hurt and upset. I felt dishonoured, but I wasn't angry at him for doing this. Then I started to get angry, and that's what changed. I just said that I'd had enough. I can't take this anymore and I don't need to take this anymore. I at that point started a part-time job. And I thought well, I **can** do this.
>
> I mean, I did, I believed her that I was a bad little girl and that I was just seeing things that weren't there and I was like someone with a serious problem, that I wanted to die and my Mom was a wonderful Mom and, you know, things like that but then when I met my own father I knew, I know, as soon as I knew, I was just like "Bam".... I think if she would acknowledge it and say, "Yes I did treat you differently." But she is in total denial.
>
> I do only know that we have had some boys in our town that were experiencing, you know, I know what they did and, I told my Mother and my Mother told me that, " Well, you caused it." And she gave me it for that. I know only, she just grabbed the stick and just gave me a licking.... It was the boys fault and they were trying to control or dominate me.

Impact of experience, treatment. At earlier points in the process, when participants had experienced invalidation and a lack of connection to others or themselves, they pursued old patterns based on their evaluation of worthlessness and helplessness. With their new experiences of validation and connectedness, and their growing self awareness, they learned to evaluate the impact of their behaviour, experience and treatment based on their own needs and expectations. They rejected what was not helpful, and what was negative and felt bad, disengaging from messages, choices, judgements or treatment viewed as not understanding them or as inconsistent with their experience, knowledge and self awareness. They valued and maintained contact, counselling and treatment they experienced as helpful. They validated therapy and the process of healing when they felt better, when they experienced physical changes and changes in their responses, when they found enjoyment and emotional connection and when their suicidal urges ceased.

> "This situation does not bother me in the same way it bothers you." And lately, "Talk to him, don't talk at me," which is a thing that I have been doing when, since I started learning about boundaries and everything...and if (partner) and (daughter) get in an argument, it's their argument, but it's an old habit of both of them to come and drag me into it, and I have had to bite my tongue and step back and say "This is not my argument. You have to sort it out between you. I'm tired of being in the middle. You figure it out with him. If you have questions, go ask him."
>
> I had a psychotherapist for a little while who used some sort of therapy and stuff, because she thought I was getting, sort of, that I had a phobia sort of about it. I may have been but I think it was just a normal reaction to rape.
>
> I don't think this person understood. I don't know. He was like a big friendly teddy bear but... well, I'm sure he was good, but he wasn't good for me.
>
> This friend was watching. She said that she, one of the first, after about the fourth treatment, she saw a light behind my eyes, she said, "Your eyes were just like dead, like no affect, for these two years." And she saw that. She said, "I don't think you saw the difference." She said "I could see some energy and some life, it was like life coming back".... After the sixth ECT treatment or the seventh treatment, I thought there was one more for the first course eight treatments and Dr. and I talked and I said, "I think I'm feeling better." I said, it was "I think" because I was, I was so terrified that, to trust it, you know, and he said, "Well, you know, let's stop at this and let's monitor it."
>
> One day I did something and reacted different and it triggered, "I haven't self abused, in how long? Let me think back to the last time and what I did."
>
> Since last year and a half the aching has gone out of my bones. My bones ached all the time. I felt internal ache. Physical pain all the time. It's like a nagging pain. I have had a lot of people say, you know, what have you done, because you look very, very relaxed? And a lot of the aching is gone from my bones.

Selecting and determining goals. The process of healing was recursive, moving back and forth between experiencing painful states and resolving feelings and issues. A variety of actions, behaviours and goals were determined and acted upon throughout the process. Participants pursued education, skills, employment, relationships, support, treatment and information. They changed their behaviour and environments. They discarded alcohol, left abusive relationships and broke limiting rules. They limited and controlled their behaviour despite strong impulses. They engaged in self care and practised strategies: monitoring cues, altering self talk, choosing self affirmation over self abuse and processing feelings.

> Different things like that, and it's very hard to hit yourself when you're standing in front of the mirror saying, "I am a good person", or saying, "I'm having this bath because I deserve this time alone," when you're trying to do deep breathing exercises and concentrate... when you're trying to do visualization, you can't hit yourself, it's not, they don't go together.
>
> I had fantasies, I had inappropriate anger, red flags, I looked at the cues, they didn't work and then I called the Dr. So I did the right thing which was a, I'm thankful for it too. That I made the choice not to let it go any further. I called Dr. ... and I'm doing the right things to get myself back on track again, and I'm getting there.

New Patterns: Honouring Self

The new patterns which emerged from participants' descriptions were evident in the formation of attitudes which shaped anew how they regarded themselves and negotiated life. These attitudes were the antitheses of worthlessness, helplessness and hopelessness and had cognitive, emotional and behaviourial elements. The participants learned they could value and accept the self, negotiate and act on their own behalf and believe in their ability to do so and endure.

Perspectives on self-self accepting.

Participants' descriptions contained numerous references to the place of pain being not feeling valued or loving themselves. They realized they hadn't attended to their own needs, but had engaged in caring for others over the self. They learned to honour the self and let go of their motivating need for approval from others. They shifted away from their monocular focus on others, husband, family, friends or parents, to a focus on the self. They discovered that attending to the self was permissable, not punishable; that they had a right to set boundaries, express themselves, protect themselves and pursue their own needs. They learned they could be a friend to themselves, trust themselves and nurture their selves. They recognized and owned the part they had played in creating their own pain. They engaged in self reflection, focused on self care, and provided the self with the love and nurturing they hadn't received and had longed for. They congratulated and appreciated themselves and others, acknowledging the validation of self, feelings and experience they received through friends, family, groups and/or helpers. They experienced a shift from worthless to worthy and from selfless to self. They began to see themselves as caring and helpful, aware of their lives, worth and identities. They felt self reliant and in control, and enjoyed feeling good about feeling good. They accepted the struggle to fully appreciate the self, including the shame and dark side, and that finding and becoming one's own person is a difficult process. They had become engaged and committed to the journey of the self.

> First of all, it was a chore set for me. (Counsellor) said, "You must show me one thing every day, "so I would be concentrating on what am I going to do today, and if I had bathed two days in a row, I'd better not have a bath again, I'd better come up with something better for her. It was for her. And then all of a sudden it was "I'm having a bath tonight because I can't take the rest of the household and I need some quiet time".... And it, it, because at the beginning I was doing them for her, but somewhere along the line it became "I'm doing this", and then the realization came, "I'm doing it for me".... I was really doing things for myself, and the world didn't fall down.

> I also in there recognized that I have the little girl in me and I actually went out and bought a birthday cake and had Happy Birthday Little Girl written on it, and the clerk looked at me, I said 'That's what I want. Little Girl'.
>
> Well, I left several times, and he would always pursue me... and I was living virtually in fear from the last time we got together and I thought that it was ridiculous. I just didn't know what to do right then. By that time I had heard, because my Mom had said, because sister had told to her as well, they'd talked about it, and Mom had said, "She is married to a batterer and she should do something about it, like go to a transition house or something." It honestly hadn't occurred to me before that.
>
> It's a big revelation. I do have a life. That was a big awareness for me. I always figured that I live for other people. And I recognized in the last year and a half I do have a life. Like I finally have a character, a personality and an identity.

Perspectives for living-self advancing. Participants discovered they could act on their own behalf and from the truth of their own experience. They realized that by breaking the silence and communicating their feelings and needs directly, they opened the way to knowing themselves; becoming known and knowing others. They discovered that the world does not have to be as safe to feel safe in life, that they did not have to be isolated to be safe, and that their new understandings could withstand invalidation by others. They became able to fear, risk and face the future. They recognized the value and benefit of maintaining connection with the self and others, and began to accept that others may not, or cannot, support or understand them or meet their needs. They realized past abusers could not harm them anymore. The emotional void was replaced with enjoyment in living and they were able to find their sense of humour and the ability to laugh at what used to be painful. Dreams had shown peace in death, and they were finding peace in life with friends, activities, accomplishments, their own choice of limits and the pursuit of purpose and value in living.

> Keeping out of that powerless place. It's a real challenge. It's a challenge today. I've taken some courses, working through the fear, staying committed. Getting some kind of meaning in life and running with it. Getting to know myself. Talking to the trees. Coming out of that space of aloneness.

Perspectives on healing and therapy-self enduring. The participants' perspectives on healing and therapy were learned as they lived it, as they experienced validation and learned to cope in new ways, breaking old patterns and establishing new ones. They learned they could recover and heal, that they could endure. In the dialogues of their paths to recovery, they described healing as beginning with the validation by others and the self as they focussed on self care and feelings. They were clear that their suicidality didn't change until they started to feel and process their feelings. Dealing with anger was critical, and experiencing and exploring their anger stimulated choices, decisions and action.

They described healing as doing little things one at a time, and discovered that a focus on suicide was only the outer layer. They learned that treatments, counselling, counsellors, friends and helpers focus differently, and that setbacks were to be expected and natural. Healing and therapy were described as 'distilling stored tainted emotions'. They realized through the process of healing they could manage difficulties and feel their feelings without becoming suicidal, and that they could choose and re-decide to live.

> Cause I had just gotten full, and that's the only way I can describe it. It's like a pitcher of milk and there is no room for any more milk, but you have all this milk, and all this other milk to put in, so somehow or other you've got to get rid of all the sour parts, and so you can make room for more milk, and I was full... full of different emotions, and what happens, what I think happens, is that the good stuff in there was being tainted by the bad stuff... and it was beginning to sour.

Synthesis of the Healing Experience

The participants' journeys away from the self began in the context of what they lived. Participants experienced loss, negative interaction and invalidation in a variety of forms and intensities. They did not feel they belonged or were welcome in their worlds. They felt worthless. Participants learned to cope with what they lived in order to survive, physically and emotionally. They found ways to protect the self and struggled to find value and meaning in their lives. Over time, when the struggle did not deliver them from their difficult situations or the feelings of worthlessness, they experienced helplessness and hopelessness as well. Suicidal crisis followed. Awareness of their crises as suicidal, varied. For each participant, acknowledgment of suicidality eventually came, and for some this was shocking. This awareness catapulted some participants through their crises, with significant shifts that brought them to a new place of regard for themselves and negotiating their lives. For others, many crises occurred, and bit by bit they began the journey to discover and accept their worth and right to pursue life and their ability to do so.

The journey back to the self frequently began in crisis with reconnection to the self through internal shifts; or in contact as they reached out to others, disclosed and shared themselves, and experienced support and validation of their selves, their struggles and their painful feelings. Not all crises or contact brought connection. Some participants experienced further loss and/or invalidation which re-evoked old patterns of coping, deepening the disconnection. When there was connection, they experienced support and validation as permission to be with the self, to feel and understand experience.

They began to connect their feelings to the events and interactions that precipitated them, both the triggering events and the underlying patterns they had learned as a response to living. A significant connection was discovering and understanding their patterns of becoming suicidal. They developed an awareness of how they learned this pattern, historically, through discovering the path that led to the need for escape and the conclusion this meant death and killing themseves. They developed awareness of their triggering patterns and their automatic conclusion when they experienced feelings, and connected these feelings to experience.

Through opening themselves to feelings, experiencing the feelings and connections to issues and interactions, participants identified their fears, clarified unfinished business and articulated their anger. They struggled between escaping from or staying with the pain of feeling, owning and accepting what they felt and dealing with what that meant in their beliefs, behaviours, interactions and environment. The familiar pattern of coping as helplessness, worthlessness and peace in death was often triggered alongside glimpses of a new and unfamiliar pattern of having worth, the right 'to be' and the ability to create change. The struggle with responsibility to and for the self was initially an unaccepted, fearful and formidable challenge. This challenge was accepted suddenly through crisis, or incrementally over time as they became aware. Awareness was developed as they listened to the self; stayed present and connected to others and their feelings; distinguished their needs, limits and boundaries from others'; expressed and communicated their feelings and needs; and received validating feedback.

Participants were affirmed and validated when they were believed and valued. In response to this validation they began to believe themselves and their experiences, and to actively evaluate and express their experience based on new parameters of self-trust and self-honour rather than the old pattern of worthlessness, helplessness and hopelessness. They became able to determine and act on their own goals and values, pursuing a variety of choices and activities. Through these changes they discarded old patterns and established new ones. The return to self was accepting the self, pursuing life and believing in their ability to do so. They chose to trust and honour the self and live. Through their acceptance and contact with the self and others they found emotional connections and enjoyment in life where once there was pain and fear. They had moved from imaging peace in death to experiencing peace in life.

Throughout the process of healing, as a return to self, participants developed new perspectives on the self and living which were the antitheses of worthlessness, helplessness and hopelessness. These patterns encompassed the beliefs, feelings and actions of being self accepting, self advancing and self enduring. These perspectives grew out of the process of healing as they experienced validation and learned self trust. They began to conquer their emotional dependence and despair. They became able to risk and to face the past and the future, managing their fears and feelings without becoming suicidal. They opened to knowing themselves, becoming known and knowing others. They opened to life, accepting the journey of the self.

CHAPTER FIVE

DISCUSSION

The Data Revisited

The phenomenon of healing from suicidality was the focus of this investigation. Participants who had been suicidal were asked to describe what was important and helpful to them in the process of healing, and they began with descriptions of when they were suicidal. A critical element that emerged in the participants' explorations was that the process and issues involved in becoming suicidal were intertwined with the process of healing. An integral part of their healing was discovering their patterns and paths to suicidality. Therefore, their descriptions and the resulting themes illuminated the process of moving towards suicidality and the process of healing.

The metaphor of 'A Journey Away and Return to Self' describes the dynamics that emerged. A journey away from the self describes the participants' suicidal processes as they disconnected from others and from the self: their feelings, self worth and ability to negotiate their lives. A return to self describes their healing experiences as reconnection with others and the self through feeling, self awareness and honouring the self, breaking old patterns and establishing new ones.

Connection is defined in Webster's dictionary as a linking together, the relation between things or surroundings that depend on or follow each other and affect and influence meaning or context. The participants' descriptions were about connection in many forms and in many ways.

Connection, disconnection, misconnection and reconnection referred to participants' relationships with their external worlds and their much deeper and more complex internal worlds. The journey away and the return to self occurred throughout the whole fibre of existence, external and internal, involving thoughts, feelings, physiology, behaviour and life circumstance.

The Journey Away From Self: Becoming Suicidal

Context and Coping

The metaphor of 'A Journey Away From the Self' described the process of becoming suicidal. The themes of context, coping and worthlessness described the participants' experiences. The context of loss, negative interactions and invalidation to suicidal behaviour is well documented, theoretically and in research investigations (Bowlby, 1969-1980; Blai, 1989; Blumethal, 1990; Brent et al., 1988; Jacob & Brown, 1990; Kelly, 1955; Maris, 1981; Maris et al., 1992; Patsiokas et al., 1979; Paykel, 1976, 1989). Also well documented is the relationship of suicidal behaviour to living in abusive situations, particularly those involving sexual abuse (Courtois, 1988; Finkelhor & Browne, 1986; Bagley & Ramsay, 1985).

Participants had coped with the context of what they lived with a variety of coping strategies: silence, withdrawal, constriction, dissociation, acting out, accepting responsibility and self blame. The variations of social, emotional, cognitive, expressive and behaviourial constriction described by the participants have been identified as part of the suicidal process (Beck et al., 1974, 1979; Bedrosin & Beck, 1979;

Neuringer, 1964; Neuringer & Lettieri, 1971; Ringel, 1973; Shneidman, 1987, 1992). Also documented in the literature is the association of suicidal behaviour with the strategies of coping through hostility and acting out (Weissman, Fox & Klerman, 1973), dissociation (Braun, 1986; Putman, 1989), and accepting responsibility (Bepko & Krestan, 1990; Kaplan and Klein, 1990).

Worthlessness, Helplessness and Hopelessness

When participants' coping strategies failed to provide relief or change they experienced despair - worthlessness, helplessness and hopelessness - and became suicidal. The participants had lost a sense of value in themselves, their future, and their ability to satisfactorily negotiate life; and this constituted the journey away from the self. Suicidal behaviour has been related to a loss of identity and the self (Kelly, 1955, 1961; Farber, 1977; Farberow, 1969; Rudestam, 1986; Shainess, 1976; Singer, 1976; Weiner & White, 1982). The role of hopelessness in suicidal intent and behaviour is well documented as a mediating factor between suicidal behaviour and depression (Beck, Kovacs & Weissman, 1975), alcoholism (Beck, Weissman & Kovacs, 1976), drug use (Weissman, Beck & Kovacs, 1979) and abuse (Emery, Steer & Beck, 1981).

Hopelessness has been conceptualized as corresponding to a wish to die (Lester, Beck & Mitchell, 1979) and in terms of negative expectancies derived from Becks' cognitive triad consisting of a negative view of self, world and experience (Beck et al., 1974). Worthlessness, helplessness and hopelessness are linked together as cognitions in Becks' theory and viewed as errors of processing, distorted perceptions and dysfunctional attitudes. They are also linked together in Shneidmans' (1987) fifth commonality, where they are considered a commonality of emotion in the suicidal state.

Worthlessness, helplessness and hopelessness were evident in the descriptions in this study as cognitions and feeling states. In terms of cognitions, for these participants, worthlessness and helplessness were not inaccurate distortions of cognitive or emotional processing in the initial construction of meaning. Their sense of worthlessness and helplessness accurately reflected the world of experience in which they lived in. If a processing error existed it would be in attributing worthlessness, helplessness and hopelessness to the self, rather than to the situation or the way they were treated, and then holding that attribution and meaning over time. During the initial construction of meaning, in their early years, this would not be considered an error; rather as developmentally appropriate and within the stages of Piaget's cognitive development or Kohlberg's moral development (Crain, 1980).

Helplessness as an accurate reflection of lived experience is also described as learned helplessness (Seligman, 1975), the learning acquired from living in an uncontrollable and unpredictable world. Helplessness and worthlessness, in the descriptions of the participants, were formed as accurate responses experiences. These responses were then reinforced and maintained over time by continued exposure to negative interactions, invalidation and unsuccessful coping strategies, and became a critical force in developing suicidal behaviour. Negative life stress and events (Rich & Bonner, 1988; Paykel, 1989), a loss of trust in self (Yufit, 1977) and worthlessness (Beck & Stewart, 1989) have been related to hopelessness, while problem solving deficits have not (Schotte & Clum, 1987).

The cognitions and feelings of worthlessness and helplessness were emphasized as part of the suicidal process throughout the descriptions in this study. Resolution of these feelings of despair was integral to healing. These cognitions and feelings formed the link, and how they were handled shifted the movement, one way or the other, between the processes of becoming suicidal or healing. Inherent in this shift and the movement towards healing was validation of and belief in the participants' experiences, by others and by the self. As one participant said, "This was the first time I was affirmed that I was not good enough". This affirmation allowed the opening to self trust and acceptance. This allowed a re-examination of past and current experiences, and the opportunity to revise the meanings, as adults, that initially created the conclusions of worthlessness and the belief they could not be active agents of change in their own lives.

Awareness and Deterrents

The function of suicide as a way to escape, to end the pain (Shneidman, 1985, 1987), to have someone know their pain, to be re-united with a loved one, or to unburden others was described by participants. These motivations and attitudes towards dealth and suicide are consistent with the literature (Maris, 1981). The desire to have someone validate and understand their experiences was seen as the part of the struggle against disconnection and the journey away from self. The motivation to suicide as a way to manipulate others was not described, nor was impulsivity a significant component of the suicidal process for the participants interviewed.

Unexpected descriptions of the lack of awareness of being suicidal were provided by participants. Repeatedly participants described being shocked by the label, suicidal, even when actively engaged in suicidal acts. They were aware of being in crisis, and the need for escape or change but not their accelerated activity towards death. In several descriptions this realization initiated healing, and the decision to live.

Participants also described times of certainty and ambivalence about dying and suicide which are consistent with the literature (Shneidman, 1985, 1987), as are the varieties and the repetitions of those behaviours (Maris, 1981). Deterrents to suicide occurred in the form of interruptions, interventions, non-lethal methods, dissociation and sheer perseverance to resist suicidal impulses. Religious beliefs, children, obligations, connections with a caring other and shifts in perspective through the impact of suicide bereavement, suicide prevention workshops or crisis were also described as deterrents to suicide and suicidal behaviour. These deterrents are well known (Maris, 1981).

Lesser known or understood as a deterrent is self-mutilation. Cutting is a form of self-injury that has been reported to be different from other forms of suicidal behaviour (Grunebaum & Klerman, 1967).

> While it is true that wrist-cutting in manipulative character disorder may define one type of 'suicide attempter' (well known to be far less lethal), many other wrist-cutters are severely depersonalized at the

> time they cut themselves. The act and the subsequent bleeding become a way of defining their own reality and of relieving the intense anxiety that usually correlates strongly with depersonalization. In this context, the cut and the bleeding end up as a countermeasure to suicide: 1) relieving severe depersonalization, 2) reestablishing contact with reality, and 3) providing palpable relief at the sight of blood, which also provides a sensation of warmth (Himmelhoch, 1988. p. 48).

Self-injury and self-abuse such as cutting, punching, piercing, hair pulling, self initiated physical fights and to a lesser degree self derogation and attributions were forms of defense against anxiety, depersonalization, dissociation and deterred actual suicide. Participants described validating their feelings, sense of self and world order in this way. These activities served to restore feeling and a sense of reality, albeit a negative one. These actions functioned to validate 'feeling bad' which was consistent with their experience. This was preferable to the anxiety and dissonance of non confirming experience, or the 'feeling nothing' of numbing and dissociation.

The Return to Self: Healing

Crisis

The capacity of crisis to bring danger and opportunity was evident in participants' descriptions. There was a critical window of opportunity in suicidal crisis for re-connection, establishing contact with others and restoring belief in the possibility of alternate solutions and their ability to find them. The correlation of withdrawal and isolation to suicidality is well documented theoretically and demographically, as is the importance of restoring contact (Blai, 1989; Glaser, 1978). Re-connection, initiating the journey back to the self, was described as beginning through crisis. For some this was a single pivotal experience; for others many crises occurred on their journeys. The capacity of crisis to create the opportunity for a shift in perspective is described in the theory of personal constructs (Kelly, 1955, 1961) and in Dabrowsky's theory of positive disintegration (Hague, 1976) in which the collapse of structures, constructs and beliefs allows for the possibility of reorganization at another level.

The significance of psychological needs, and the relationship of the difficulties of meeting those needs to the development of suicidality, were evident in the participants' descriptions. The concept of frustrated psychological needs as an important force in suicidal dynamics is recognized in a number of suicide models and is either assumed, peripheral or dismissed in others. The psychological needs described by participants are those articulated generally by Maslow (Ryckman, 1982) and more specifically by Murray (Maris et al., 1992). According to Maslow, humans have basic and growth needs arranged in a hierarchy from physiological needs, to safety needs, to belongingness and love needs, to esteem needs, and then to self actualization needs. The participants repeatedly described the frustration of these needs, particularly safety, belonging and esteem needs. When participants connected with others and experienced support and validation, and these psychological needs began to be met, they received permission to accept the self and experience, and to discover who they were and could become. They became 'unstuck' and were able to move towards higher hierarchial and growth needs.

Misconnections

Connections were not always established through crisis or contact. Although this investigation did not set out to gather descriptions of experience that were not helpful in the healing process, these descriptions emerged throughout the interviews. Many misconnections occurred through treatment errors. A zeal to instill hope, increase options, problem solve or simply medicate to move away from suicidality missed validating the individuals experience, which automatically invalidated their feelings, construction of meaning and efforts at coping. 'Misconnections' were further described as occurring through disbelief, denial, or dismissal of the participants and their experiences, creating a continuance of frustrated psychological needs. These misconnections reinforced the experiences of loss, negative interaction, invalidation, worthlessness, helplessness, and hopelessness. Studies of treatment errors with suicidal individuals indicate that the least consequence of errors is that they do not interrupt the suicidal pattern and the worst consequence is their contribution to further suicidal acts or deaths by suicide (Jorstad, 1987; Kreiger, 1978; Maltsberger & Buie, 1974; Modestin, 1987; Swenson, 1986). For the participants interviewed, with these missed connections of contact, new information or direction, they simply continued the old patterns. The pattern of suicidal behaviour was not interrupted.

Connections With Others

A difficult and painful part of healing was reaching out or reaching in breaking through cognitive, emotional and behaviourial barriers designed for protection and survival. Through crisis and connecting with others, participants began the movement towards breaking the barriers and connecting with the self. This movement depended on having someone interact with them in a validating way. Validation involved someone external, not necessarily a therapist, accepting and affirming their experiences, which affirmed the self. The participants repeatedly described experiencing the presence of a validating relationship before they could trust the self. The power of the relationship to provide the context and catalyst for change is central to Rogers' person centred therapy (1959, 1961). The importance of the relationship to the healing process has been documented by others (Frieswyk, 1985; Patterson, 1984), and is believed to be encouraged through the non-specifics of therapy (Kazdin, 1979; Wilkins, 1979).

Connecting With Self

Participants' ability to reach in and connect with the self and to examine the self and the function of behaviour had been blocked through emotional, cognitive and behaviourial constriction and their experience of despair. Through connections with others they opened themselves to discovery and self awareness. They found their feelings and connected them to their experience, identifying their patterns and paths to suicidality, their anger, unfinished business and struggle with denial. Strictly speaking, participants had not been paralysed or helpless, or unable to evaluate their experience, but rather were frozen through invalidation and constriction into initial constructions of meaning and behaviour. Focuses on early learnings in the construction of beliefs and meanings and the role of constriction in coping are outlined in cognitive theories and therapies and in family or origin issues of attachment and loss (Adams, Bonchong & Steiner, 1980; Bowlby, 1980; Barach, 1991; Murphy, Armstrong & Hermele, 1979; Sorensen & Rutter, 1991).

The Stone Center model of women's relational self development sees women as seeking a relational process (Miller, 1986) rather than seeking increasing levels of separation and autonomy as in Erickson's model of development (Ryckman, 1982). Kaplan and Klein (Jacobs & Brown, 1989) stressed the importance of disconnections to the development of suicidal behaviours in women. For the participants in this study, disconnections and misconnections were significant for both men and women, as were reconnections for healing. No differences were found between the sexes that would suggest that disconnections had a more significant impact on women than men. Both men and women described their healing from suicidality through reclaiming their connections to the self, others and experience.

Breaking and Establishing New Patterns

The healing process came to be understood as a 'Return to Self' which culminated in establishing new patterns. The participants engaged in a variety of activities, documented as strategies in a number of therapies, which led to breaking down barriers, discovering patterns and establishing new ones. The strategies they utilized included listening to the self, maintaining connections, determining needs, establishing boundaries and goals, increasing self expression and self care, receiving feedback from others and acting on and evaluating their own experience. These activities represent behaviourial changes, but necessarily involve cognitions and affect as well. These actions were initiated as a result of instruction in treatment; from self help activities such as reading, workshops or groups; and non-treatment contact with caring and helpful others.

An affirming and validating relationship had provided the context for internal connections and change, allowing interventions and strategies to influence cognitive, emotional, behaviourial and situational barriers. Cognitive and behaviourial interventions frequently reached an impasse or were ineffective until they were combined with an affective component. Participants had disconnected from their ability to feel or to follow their feelings to things other than the conclusion of despair - worthlessness, helplessness and hopelessness. These feelings were an automatic trigger to suicidal behaviour or self abuse. Allowing, acknowledging and identifying feeling led to the discovery of patterns and the reconnection of feelings to the events to which they were associated in meaning.

Repeatedly, participants described the revision of meaning coming about when their feelings, precipitated in experience, were understood and validated, allowing them to shift their feelings of worthlessness out of themselves and attribute them to contextual and coping dimensions. They discovered they were not worthless, but had been treated in that way.

This shifted the suicidal conclusion, and helplessness and hopelessness as well. The focus on feelings and on honouring the self through self care allowed them to connect with their feelings and patterns and return to their selves. The experiences of feedback from others, and their own experiences evaluated through feeling, along with the recognition of changes stimulated and encouraged the process of healing. Through following their feelings, participants revised their views of the self, their experiences and their belief and ability in their right to pursue their own needs, creating healing and the decision to pursue life rather than death.

A critical aspect of participants' experiences was the equation they had created between 'feeling bad' and suicide. **To feel Worthless + Helpless + Hopeless = Death + Suicide.** For most of the participants, this equation had been initiated in their early years and had been reinforced and triggered through following life experiences. One participant differed, as her suicidal decision was not a conclusion from repeated negative interaction and invalidation begun as a child. Following surgery as an adult and the onset of depression, she experienced intrusive impulses to self harm over which she felt no choice or control. These impulses were not experienced or labelled initially as suicidal. The context of her depression, impulses to self harm and inability to secure relief served to stimulate the suicidal conclusion and decision. She came to feel worthless, helpless and hopeless and concluded on suicide. She struggled with this conclusion and persevered, learning ways to cope. Release from the terror of her experience and the comfort she found in thoughts of death came from ECT. This is consistent with directives in the literature about persistent suicidality (Maltsberger, 1991). This participant's experience, although with differences, validates the healing theme pattern representing factual variation with stability of meaning of the suicidal process and healing.

A focus on affect and the importance of feeling (Cavenar & Nash, 1977; Leonard, 1987; Nelson & Gruenbaun, 1971), and on utilizing feeling to gain access to self information (Shapiro, 1985) was utilized in a few treatment approaches. Affect is not typically a primary focus of many psychosocial therapies. The participants' descriptions indicate that focusing on affect was a central and critical component of their healing that enabled the shift away from worthlessness, helplessness and hopelessness. Their experiences indicate that a focus on affect is underemphasized in most treatment approaches.

Overall, the participants' descriptions illuminated the process towards suicidality and the process of healing. The metaphor of 'A Journey Away From Self' described the participants' suicidal processes as they disconnected from others and from the self; their feelings, self worth, and ability to negotiate their lives. The metaphor of 'The Return to Self' described the participants' healing experience as a reconnection with others and the self through feeling, self awareness and actively honouring the self. Overall, and through each step, this involved focusing and dealing with the interrelated aspects of feeling, thinking and doing related to each theme in order to break old patterns and establish new ones. The new patterns were the antithesis of worthlessness, helplessness and hopelessness. These new patterns encompassed the beliefs, feelings and actions of being self accepting, self advancing and self enduring.

The synthesis and thematic analysis were taken back to the participants for their review and feedback. Several descriptive components within the themes' generalized descriptions that different participants had not described were acknowledged as being part of their processes as well when they reviewed the analysis. Participants experienced a 'goodness of fit'; the themes reflected and resonated with their experience, validating the final thematic structure.

A quantitative study undertaken to ascertain variables that may contribute to the resolution of suicidality was reported at the 27th Annual American Association of Suicidology Conference (Judd & Jobes, 1994). Variables were identified which appear to be linked to suicide resolution. These variables, identified by clients and their counsellors, focused on feelings, the importance of a validating relationship and working on the self. The results of Judd and Jobes quantitative study and this phenomenological study, reported at the same conference, appear to reciprocally support one another in their findings of what promotes and contributes to the process of suicidal healing.

Implications for Suicide Prevention and Treatment

The themes of 'A Journey Away and Return to Self' replicate the findings of researchers from a variety of theoretical persuasions, affirming many of the factors that have been identified as being involved in suicidal and healing processes. The themes illustrate the interconnectedness, interaction and impact of internal and external factors on individuals. The naming of these factors and how they were experienced provide an enriched understanding of suicidal behaviour and healing. This understanding, formed through the thematic analysis of the participants' descriptions contributes a perspective on healing which may be helpful for conceptualizing and guiding treatment with other suicidal individuals and the complex problems they bring to counselling treatment settings.

The major implications of this phenomenological thematic analysis relate to how the suicidal and healing processes are conceptualized; and from that conceptualization, how the focus and delivery of treatment facilitate healing. Equally important, they may be applied in the education and training of those working with suicidal individuals.

Conceptualizing Treatment

Disconnection and Reconnection

Through the analysis of themes, the suicidal process came to be understood as a process of disconnection and the loss of self: an individual's value, future, ability to feel or negotiate life. Hence the metaphor, the journey away from self, and the understanding that this journey occurred throughout the whole fabric of the participants' lives, external and internal, involving their thoughts, feelings, physiology, behaviour and life situation. Healing was understood as a process of reconnection with others and the self, and of coming to honour, know, accept and advance the self in affective, cognitive and behaviourial dimensions.

Multi-dimensional Treatment

The participants' descriptions direct a view of healing that takes into account the interconnectedness, interaction and impact of factors across a variety of dimensions. The implication for treatment is that for treatment to facilitate reconnection, it is to be multi-dimensional, moving beyond uni-dimensional interventions and integrating a variety of disciplinary strategies. This perspective challenges the fragmentation and compartmentalization of uni-dimensional treatments that decontextualize affect, cognitions and behaviour, in time, from each other or experience. Therefore, for healing to occur from this perspective, treatments are to focus on feelings, cognitions, behaviour and the life situation. It directs attention to the therapeutic relationship and integrated interventions involving self awareness and insight, restructuring and reframing cognitions and meaning, dealing with feelings, expressive dimensions and activities reinforcing these interventions.

Facilitating Treatment: The Power of Validation

The process of becoming suicidal is about disconnection and despair and the healing process is about establishing reconnections to others, the self and experience. Treatment is about facilitating those reconnections, effectively developing new patterns and breaking old ones.

A critical implication for treatment is acknowledging the dominance of the role of despair in becoming suicidal and its resolve for healing. The participants presented helplessness as the belief in their inability to effect change which, when combined with their feelings of worthlessness, created hopelessness and sense of despair. These cognitions and feelings and how they were handled shifted the movement, one way or the other, between the processes of becoming suicidal or healing.

A validating relationship facilitated reconnection and healing. The movement towards breaking the barriers designed to protect and survive (and maintain old patterns) began in crisis, when contact established connections with others, and when participants experienced internal shifts allowing connection with experience and the self. The movement to connecting with the self frequently required someone interacting in a validating way, accepting and affirming them and their experiences. The presence of a validating relationship acted as an external anchor and a catalyst for the development of self trust.

Misconnections were experienced as negative interaction and invalidation that reinforced despair. Crisis and contact did not always establish connections. Participants described numerous misconnections that occurred through treatment errors, which is consistent with the literature. The most notable for participants was their perception of the lack of acceptance of and respect of their experiences and the integrity of their persons by helpers. Respect, integrity and positive regard are important components of healing and developing self trust. Participants' experiences draw attention to the combined absence of knowledge, ability and willingness of helpers to identify suicidal impulses and behaviour. The education of helpers on the complex dynamics of suicide has been identified as a prevention strategy (Krugley, 1985; Maltsberger, 1991; Peterson & Bongar, 1990), and strategies for dealing with helpers' internal responses and resistances to working with suicidal individuals have also been documented (Jorstad, 1976; Krugley, 1985; Maltsberger & Buie, 1974).

The error in disbelief, denial or dismissal of the participants and their experiences and in treatment through zeal to instill hope, increase options, problem solve, or medicate was that helpers missed validating the person, the persons construction of meaning, feelings and coping efforts, all of which deepened the disconnection and reinforced participants' experience of despair. Participants were able, with validation, to begin to change meaning and behaviour. This understanding is consistent with Rogers' (1959, 1961) self valuing process; and, from the participants' experiences, is essential in interrupting the suicidal process.

Validating experience, feelings and constructions of meaning was central to reconnecting and healing. Worthlessness, helplessness and hopelessness have been linked together and viewed as distorted cognitions or emotions in the suicidal state. In this study, they were described as cognitions and feeling states. For these participants, worthlessness and helplessness were not inaccurate distortions of cognitive or emotional processing in the initial construction of meaning. Their cognitions and feelings accurately reflected their world of experience, and they were reinforced and maintained over time by continued exposure to negative interactions, invalidation and unsuccessful coping strategies.

The understanding of the participants was that awareness and validation of the self and experience contributed to resolving cognitive, emotional and behaviourial constrictions. The validation of their feelings and their construction of meaning affirmed their processing (cognitive and emotional) of negative experiences. This affirmation allowed for the development of self-trust.

Actions validated patterns and the sense of self. Participants described repeatedly acting to maintain their patterns and their experiential sense of self as worthless and helpless. This was their comfortable, consistent and congruent world and sense of self, cognitively and emotionally. This pattern led to suicidality. With external validation, participants reconnected to experience, shifting attributions from the self to the situation or the way they were treated. They came to know, to value and to act for the self in new ways that countered the feelings of despair. Subsequent self-evaluation and validation encouraged them to maintain their new behaviours and attitudes. Without reconnection and validation of the self and experience they continued to act to validate the old patterns that maintained their suicidality.

Resolving suicidality required dealing with the underlying issues, events and disconnections. The participants described their movement away from suicidality as not occurring from the resolution of crisis per se but of the factors involved in disconnection which gave rise to worthlessness, helplessness and hopelessness. Participants' were articulate in discriminating between precipitating and underlying factors, and understood that dealing with the precipitating factor and acute crisis was only the surface, or outer layer.

Distinctions between acute or chronic suicidal crisis, precipitating or underlying factors, and concomitance or causality are important here. Most suicide intervention has been crisis oriented and focused on acute crisis, with treatment typically aimed at keeping the individual alive and ameliorating precipitating factors. The importance to treatment of the distinction between these factors and their relationship to suicidality as concomitance or causality is a thorny issue, and it is intensified by disciplinary bias.

> "Proponents of all the approaches need to be vigilant that they do not confuse concomitance (events [in the brain, in the blood, in society, in interpersonal relations, within the psyche] that happen at the same time as heightened suicidality) with causality (events that necessarily must precede the onset of a suicidal state). It is the causally related events that present avenues to effective prevention" (Shneidman, 1992, p. 62).

Professionals' disciplinary lenses have determined concomitance or causality and the avenue through which treatment is directed. The participants' lens of experience directs treatment to resolving disconnections and their impact by focusing on the underlying issues and events and on how these were experienced in feeling and meaning.

The path to discovering disconnections and their impact was through affect. Patterns and the meanings of events that had led participants to conclude on death and suicide were discovered through a focus on feelings. The sense of self, formed through integrating experience, was discovered through feelings, and this was integral to the development of self-trust and a perspective of self-worth. This process involved feeling their feelings, identifying and discriminating their feelings from thoughts and actions, and distinquishing their feelings, as they were triggered in the present, from events in the past.

Affect was important to participants in this study in several different ways. Their descriptions of the power of validation (itself an affective experience); the critical importance of feelings and emotional knowing; and the function of actions to validate feelings, patterns, a sense of self and reality all indicate that affect has been underemphasized as a critical avenue and component of treatment.

Feelings, particularly those of worthlessness and helplessness, were described as propelling or compelling participants to suicidal behaviour. Meanings and labels were described as coming later, and often externally, as a way to understand and describe behaviour and experience. This is central to the debate and the assumption that cognitive processes precede and overpower affective processes. "Contemporary research in sensation and perception has amply corroborated...that all perception is based in feelings and felt contrasts" (Mahoney, 1991, p. 189). The function of cognitive mediation in the genesis of emotions is being reviewed, and

> overwhelmingly supports the conclusion that affective feelings (which I believe are the essential ingredient of emotions) arise more from the genetically governed nature of certain types of circuits within our brains rather than from the lessons we learn in the world. Not in the least would such a principle of affective primacy in inheritance negate or deny the fact that our appraisal of our everyday experiences is the major trigger of emotions in our adult lives (Panksepp, 1993, p. 339).

A renewed interest in affect, and in its relationship to cognitions and to self organization, marks the movement from an era which neglected emotions and subjugated them to cognition. For the participants, accepting and experiencing their affect, and having their emotional knowing validated led them on their journey to the self.

> A developmental or constructivist perspective considers emotions to be primitively powerful **knowing** processes that are integral to the lifespan self-organization of the individual. From this view, emotions are still associated with episodes of discomfort and disorganization, but the latter are seen as (1) natural expressions of an individual's current personal realities, and (2) necessary (and often facilitating) elements in the reorganization of that person's tacit assumptions about self and the world (Mahoney, 1991, p. 208).

To re-iterate, the metaphor of a journey away from self described the participants' suicidal processes. They had become disconnected from others and the self: their feelings, self worth and ability to negotiate their lives. The metaphor of a return to self described their healing as reconnecting to the self, experiencing validation from others and the self, developing self trust and believing in their feelings, experience, value, future, and ability to be an active agents in their own lives. Their new patterns of self honour - being self accepting, self advancing and self enduring - were experienced in their beliefs, feelings and actions and are the antitheses of worthlessness, helplessness and hopelessness.

This study replicated many of the identified factors and dynamics of suicide and suicidal behaviour. The understanding of the thematic analysis of participants' descriptions contributes a conceptualization of suicidal and healing processes and treatment. The participants' descriptions of healing call for the integration of affective, cognitive and behaviourial interventions. A pivotal component for participants was the resolve of their feelings of despair which shifted the choice from death and suicide, to life. This component directs treatment to a focus on feelings and emotional knowing in order to develop awareness and behaviours that actively honor the self. Overall, the implication for treatment, of what made the difference in healing, is that treatment focus on reconnection: with others, with experience and with the self. This allows for the development of self-trust and for coming to know, honor, accept and advance the self. For treatment to be effective, based on the analysis of the participants' descriptions of their experiences, interventions must necessarily integrate and incorporate multi-dimensional interventions.

This perspective is unique, derived as it is from individuals' descriptions of their healing experiences. Participants being suicidal or suicidal no longer is the verification of what made a difference for them. This understanding, evolved from the thematic analysis of descriptive experiences, may be helpful in conceptualizing and guiding treatment with other suicidal individuals.

Limitations of the Study

The purpose of this research was to explore the experience of healing of once suicidal individuals. Their descriptions of healing provide an understanding of, and not an explanation for suicidal healing. This phenomenological study of the complexities of healing is an attempt to bring together research and counselling practice; however, the issue of objectivity and subjectivity remains as a fundamental difference between natural and human science perspectives when it comes to the relationship between observing facts and interpreting meaning. This limits the reception of phenomenological studies.

Most studies of treatment effects are with in-patient populations and this investigation was with individuals whose treatment contacts consisted of private counselling, self help groups or emergency medical interventions. The study did not investigate a specific treatment in a specific setting over a particular period of time. The time span described by most participants extended through several decades and included a variety of treatment experiences. As changes and healing were reported to be gradual and recursive, there is an increase in the number of extraneous experiences that may account for change and a decrease in the ability to associate change with any particular event. In that the experiences of healing described by participants were stable, the reported process may be considered to account for their healing, even though specific experiences may not.

This study was based on interviews with nine participants, and its representativeness and generalizability remain open to question. Additional verification may be achieved through replication. Further study may attest to the internal cohesion and validity of the themes found in this study through empathic generalization and perspectival intersubjective agreement. Verification can be achieved through understanding and testing this formulation against the experience of others.

The themes were based on descriptions of adults and there may be differences for youth or the elderly. Descriptions were provided by both men and women, and no differentiations were apparent based on gender.

Implications for Research

A variety of research investigations may be considered based on this study of the process of healing. The participants in this study validated the overall thematic structure that was generated from all the participants' descriptions. To further examine the validity of the themes, another sample of once suicidal individuals could be asked to review the themes, or a questionnaire of statements based on the themes could be developed and a larger population surveyed. These investigations may reveal information on how this process may differ for men and women, or for different age groups.

This investigation of healing was from the perspective of the once suicidal. Another investigation that may illuminate healing and treatment would be to gather descriptions from therapists of their experience of helpful interventions with suicidal individuals. Further, a comparison of these perspectives would add yet another dimension to our understanding of therapeutic interventions and the process of healing.

Specific hypotheses based on this perspective of healing may be investigated in further research; specifically the central theme of healing understood as healing the combined feelings and meaning of worthlessness and helplessness. In this study, the feelings of worthlessness and helplessness performed as automatic triggers to suicidality and through their resolve, discovered in feeling, healing occurred. This may be explored in further detail, along with the more general role of affect as a knowing process in developing meaning and self organization.

REFERENCES

Alvarez, A. (1971). The savage god. London: Weidenfeld and Nicolson.

Achte, K. (1990). Brief psychotherapy with suicidal persons. Crisis. 11, 1, 1-6.

Adams, K. S., Bonchong, A. & Steiner, D. (1980). Parental loss and family stability in attempted suicide. Archives of General Psychiatry. 39, 1081-1085.

Bagley, C. & Greer. (1971). Clinical and social predictors of repeated attempted suicide: A multivriate analysis. British Journal of Psychiatry. 119, p. 515-521.

Bagley, C. & Ramsay, R. (1985). Disrupted childhood and vulnerability to sexual assault: Long-term sequels with implications for counselling. Paper presented at the Conference on Counselling the Sexual Abuse Survivor. Winnipeg, Canada.

Barach, P. M. (1991). Multiple personality disorder as attachment disorder. Dissociation. IV(3), p. 117-123.

Barraclough, B., Bunch, J. & Nelson, B. (1974). A hundred cases of suicide: Clinical aspects. British Journal of Psychiatry. 125, 355-373.

Beck, A. T. (1974). Cognitive modification in depressed and suicidal patients. Annual Meeting of The Society for Psychotherapy Research. Denver.

Beck, A.T. & Stewart, B. (1989). The self concept as a risk factor in patients who kill themselves. Unpublished manuscript. Cited in Maris et al., 1992.

Beck, A. T., Beck, R. W. & Kovacs, M. (1975). Classification of suicidal behaviours: Quantifying intent and medical lethality. American Journal of Psychiatry. 132, p. 285-287.

Beck, A. T., Kovacs, B. & Weissman, A. (1975). Hopelessness and suicidal behaviour: An overview. Journal of the American Medical Association. 234, 1146-1149.

Beck, A. T., Kovacs, B. & Weissman, A. (1979). Assessment of suicidal ideation: the scale for suicide ideation. Journal of Consulting and Clinical Psychology. 217, 343-352.

Beck, A. T., Resnick, H. P. L. & Lettieri, D. J. (1974). The Prediction of Suicide. MD: Charles.

Beck, A. T., Weissman, A., & Kovacs, M. (1976). Alcoholism, hopelessness and suicidal behaviour. Journal of Studies on Alcohol. 37, 1, 66-77.

Bedrosin, R. C. & Beck, A. T. (1979). Cognitive aspects of suicidal behaviour. Suicide and Life Threatening Behaviour. 9, 87-96.

Bepko, C. & Krestan, J. (1990). Too good for her own good. NY: Harper & Row.

Bergin, A. E. & Lambert, M. J. (1978). The evaluation of therapeutic outcomes. In S. L. Garfield & A. E. Bergin. Eds. Handbook of psychotherapy and behaviour change. New York: John Wiley & Sons.

Blai, B. (1989). Health consequences of loneliness: A review of the literature. Journal of American College Health. 37, 4, 162-167.

Blumenthal, S. J. (1990). An overview and synopsis of risk factors, assessment and treatment of suicidal patients over the life cycle. In S. J. Blumenthal & D. J. Kupfer. Eds. Suicide over the life cycle. Washington, DC: American Psychiatric Press.

Bongar, B. (1991). The suicidal patient. Washington, D. C.: American Psychological Association.

Bowlby, J. (1969-1980). Attachment and loss. New York: Basic Books.

Braun, B. G. (Ed.) (1986). Treatment of multiple personality disorder. Washington: American Psychiatric Press.

Breed, W. (1972). Five components of a basic suicide syndrome. Life Threatening Behaviour. 2, 1, 3-17.

Brent, D.A., Kupfer, D. J., Bromet, E. J. & Dew, M. A. (1988). The assessment and treatment of patients at risk for suicide. In A. J. Frances & R. E. Hales. Eds. Review of Psychiatry. 7:353-384. American Psychiatric Press.

Brent, D. A. (1987). Correlates of the medical lethality of suicide attempts in children and adolescents. Journal of American Academy of Child Psychiatry. 26, 87-89.

Budge, S. (1983). A critical look at the psychotherapeutic outcome research paradigm. Psychotherapy: Theory, Research and Practice. 20, 3, 294-306.

Callahan, J. (1993). Shneidman relates controversies in suicidology. Newslink: American Association of Suicidology. Col: Denver.

Cavenar, J. O. & Nash, J. L. (1977). Affect discharge. Military Medicine. 465-466.

Chowdhury, N., Hicks, R. C. & Kreitman, N. (1973). Evaluation of an aftercare service for parasuicide patients. Social Psychiatry. 8, 67-81.

Clarke, K. (1989). Creation of meaning: An emotional processing task in psychotherapy. Psychotherapy. 26, 2, p. 139-148.

Clum, G. A., Patsiokas, A. T. & Luscomb, R. L. (1979). Empirically based comprehensive treatment program for parasuicide. Journal of Clinical and Consulting psychology. 47, 937-945.

Crain, W. C. (1980). Theories of development. NJ: Prentice Hall.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King. Eds. Existential-phenomenological alternatives for psychology p. 48-71. NY: Oxford University Press.

Coombs, Miller, Alarcon, Herlihy, Lee & Morrison. (1992). Communications between parasuicides and caregivers. Suicide and Life Threatening Behaviour. 22, 3, 289-302.

Corsini, R. J. (1984). Current psychotherapies. Peacock: Illinois.

Courtois, C. (1988). Healing the incest wound. NY: Norton.

Crammer, J. L. (1984). The special characteristics of suicide in hospital patients. British Journal of Psychiatry. 145, 460-476.

Diekstra, R.F.W., Engels, G. I & Methorst, G. J. (1988). Cognitive therapy of depression. Crisis. 9, 1, 32-44.

Dilthey, W. (1977/1984). Ideas concerning a descriptive and analytic psychology. In R. Zaner & K. L. Heiges. Eds. Descriptive psychology and historical understanding. The Hague: Martinus Nijhoff.

Dew, M. A., Bromet, E. J. & Brent, D. (1987). A quantitative literature review of the effectiveness of suicide prevention centres. Journal of Consulting and Clinical Psychology. 55, 239-244.

Dorwart, R. A. & Chartock, L. (1990). Suicide: A public health perspective. Suicide: Understanding and responding. Madison: International Universities Press.

Durkheim, E. (1951). Suicide: a study in sociology. Ill: Free Press.

Dyck, R. J, Neuman, S. C. & Thompson, A. H. (1988). Suicide trends in Canada, 1956-1981. Acta Psychiatrica Scandinavia. 77, p. 411-419.

Eastwood, R. (1980). Suicide and parasuicide. Public Health and Preventive Medicine. NY: Appleton-Century-Crofts.

Elliott, R. (1985). Taxonomy of helpful and nonhelpful events. 32, 3, p. 323-328.

Emery, G. D., Steer, R. A., & Beck, A. T. (1981). Depression, hopelessness and suicidal intent among heroin addicts. International Journal of Addictions. 16, 3, p. 425-429.

Ettlinger, R. (1975). Evaluation of suicide prevention after an attempted suicide. Acta Psychiatrica Scand. 260, 11-24.

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. Journal of Consulting Psychology. 16, 319-324.

Farber, L. (1977). Despair and the life of suicide. Essence. 1, 239-250.

Farberow, N. L. (1969). Self destruction and identity. Institute of Man Symposium on Self-Destruction and Self-Creation.

Farberow, N. L. & Shneidman, E. Eds. (1961). The cry for help. New York, NY: McGraw-Hill.

Fawcett, J. (1988). Predictors of early suicide: Identification and appropriate intervention. Journal of Clinical Psychiatry. 49, 10, 7-8.

Fawcett, J., Clark, D. & Scheftner, W. A. (1991). The assessment and management of the suicidal patient. Psychiatric Medicine. 9, 2, 299-311.

Finkelhor, D. & Browne, A. (1986). The impact of child sexual abuse: A review of the research. Psychological Bulletin. Vol. 99, No.1.

Foreman, M. (1990). The counsellor's assessment and intervention with the suicidal student. College Student Suicide. NY: Haworth Press.

Freeman, A., & Reinecke, M. A. (1993). Cognitive therapy of suicidal behaviour. NY: Springer

Freeman, A., Simon, K. M., Beutler, L. E. & Arkowitz, H. Eds. (1989). Comprehensive handbook of cognitive therapy. NY: Plenum Press.

Frieswyk, M. (1985). The healing dialogue in psychotherapy. NY: Jason Aronson.

Garfield, S. L. (1978). Research on client variables in psychotherapy. In S. L. Garfield, A. E. Bergin, Handbook of psychotherapy and behaviour change. NY: John Wiley & Sons.

Garfield, S. L. & Bergin, A. E. (1978). Handbook of psychotherapy and behaviour change. NY: John Wiley & Sons.

Gibbs, J. P. & Martin, T. (1958). A theory of status integration and its relationship to suicide. American Sociological Review. Vol. 23. 140-147.

Gibbons, J. S., Butler, J., Urwin, P. & Gibbons, J. L. (1978). Evaluation of a social work service for self-poisoning patients. British Journal of Psychiatry. 133, 111-118.

Giorgi, A. (1975). An application of phenomenological method in psychology. In A. Giorgi, C. Fischer & E. Murray. Eds. Duquesne Studies in Phenomenological Psychology. Vol. 2, p. 82-103.

Pittsburgh: Duquesne University Press.

Glaser, K. (1978). The treatment of depressed and suicidal adolescents. American Journal of Psychotherapy. 32, 252-269.

Goldney, R. D. & Burvill, P. W. (1980). Trends in suicidal behaviour and its management. Australian and New Zealand Journal of Psychiatry. 14, 1-15.

Gould, M. S. & Shaffer, D. (1986). The impact of suicide in television movies: Evidence of imitation. New England Journal of Medicine. 315, p.690-694.

Greer, S. & Bagley, C. (1971). Effect of psychiatric intervention in attempted suicides: A controlled study. British Medical Journal. 1, 310-312.

Greenberg, L., Rice, L. & Elliott, R. (1993). Facilitating emotional change: The moment by moment process. NY: Guilford Press.

Grunebaum, H. U. & Klerman, G. L. (1967). Wrist slashing. American Journal of Psychiatry. 124, p. 527-534.

Hague, W. J. (1976). Positive disintegration and moral education. Journal of Moral Education. Vol. 5. No. 3. p. 231-240.

Havens, L. (1990). Clinical interview with a suicidal patient. In D. Jacobs & H. N. Brown. Eds. Suicide: Understanding and responding. Madison: International Universities Press.

Hawton, K. Bancroft, J. Catalan, J. Kingston, B. (1971). Domiciliary and outpatient treatment of self poisoning patients by medical and non medical staff. Psychological Medicine. 11, 169-177.

Health and Welfare Canada. (1987). Suicide in Canada. Report of the

National Task Force on Suicide in Canada. Minister of National Health and Welfare.

Henry, A. F. & Short, J. F. (1957). The sociology of suicide. In E. S. Shneidman & N. L. Farberow. Eds. Clues to suicide. NY: McGraw-Hill.

Himmelhoch, J. M. (1988). What destroys our restraints against suicide? Journal of Clinical Psychiatry. 49, 9. p.46-52.

Hirsch, S. R., Walsh, C. & Draper, R. (1982). Parasuicide: A review of treatment interventions. Journal of Affective Disorders. 4, 299-311.

Jacobs, D. & Brown, H. N. Eds. (1990). Suicide: Understanding and responding. Madison: International Universities Press.

Jarvis, G. K., Ferrence, R. G., Johnson, F. G. & Whitehead, P. C. (1976). Sex and age patterns in self-injury. Journal of Health and Social Behaviour. 17, 146-155.

Jeger, A. M. (1979). Behaviour theories and their application. In L. D. Handoff & B. Einsidler. Suicide theory and clinical aspects. Littleton, MA: P&G.

Johnson, S. & Greenberg, L. (1987). Emotionally focused marital therapy: An overview. Psychotherapy. 24, 552-559.

Jorstad, J. (1987). Some experience in psychotherapy with suicidal patients. Acta Psychiatrica Scand. 336 76, p. 76-81.

Judd, S., & Jobes, D. (1994). Suicide resolution: Client-counsellor perceptions. American Association of Suicidology: 27th Annual Conference. New York.

Kalafat, J. & Ryerson, D. (1993). School programs at the crossroads.

Newslink. American Association of Suicidology. 19, 3.

Kaplan, A. & Klein, R. (1989). Women and suicide. In D. Jacobs & H. N. Brown. Eds. Suicide: Understanding and responding. Madison: International Universities Press.

Kaplan, H. B. & Pokorny, A. D. (1976). Self attitudes and suicidal behaviour. Suicide and Life Threatening Behaviour. 6, 23-35.

Katakis, C. D. (1989). Stages of psychotherapy: Progressive reconceptualizations as a self organizing process. Psychotherapy, 26, p. 484-493.

Kazdin, A. E. (1979). Nonspecific treatment factors in psychotherapy outcome research. Journal of Consulting and Clinical Psychology, 47, 846-851.

Kazdin, A. E. (1981). Drawing valid inferences from case studies. Journal of Consulting and Clinical Psychology, 49, 183-192.

Kelly, G. (1955). The psychology of personal constructs. NY: Norton.

Kelly, G. (1961). The personal construct point of view. In N. L. Farberow & E. S. Shneidman. Eds. The cry for help. NY: McGraw-Hill.

Kennedy, P. (1972). Efficacy of a regional poison treatment centre. British Medical Journal. 4, 255-257.

Kessler, R. C. & McRae, J. A. (1983). Trends in the relationship between sex and attempted suicide. Journal of Health and Social Behaviour. 24, 98-110.

Kiev, A. (1975). Psychotherapeutic strategies in the management of depressed and suicidal patients. American Journal of Psychiatry. 133, 150-153.

Kohut, H. (1977). The restoration of self. NY: International Universities Press.

Kolko, D. & Brent, D. A. no date. Cognitive-behavioral interventions for suicidal youth. Handbook: Western psychiatric institute & clinic. University of Pittsburgh School of Medicine.

Kovacs, M., Beck, A. T. & Weissman, A. (1975). The use of suicidal motives in the psychotherapy of attempted suicides. American Journal of Psychotherapy. 29, 363-368.

Kovacs, M., Beck, A. T. & Weissman, A. (1976). The communication of suicidal intent. Archives of General Psychiatry. 33, (198-201.

Kovacs, M., Rush, J. & Beck, A. T. et al. (1981). Depressed patients treated with cognitive therapy of pharmacotherapy: a one year follow up. Archives of General Psychiatry. 38, p. 33-39.

Kreiger, G. (1978). Common errors in the treatment of suicidal patients. Journal of Clinical Psychiatry. 39, 649-651.

Kreitman, N. (1979). Preventive enthusiasm and scientific caution. Presentation at 10th International Congress for Suicide Prevention and Crisis Intervention, Ottawa.

Krugley, R. A. (1985). Recent advances in suicide. New Directions for Mental Health Services. San Francisco, CA: Jossey Bass.

Leonard, C. V. (1967). Understanding and preventing suicide. Ill: Charles Thomas Pub.

Leonard, C. V. (1975). Treating the suicidal patient: A communication approach. JPN and Mental Health Services. 17, 19-22.

Leenaars, A. (1991). Suicide notes and their implications for intervention. Crisis. 12,1, p. 1-20.

Lester, D. (1974). Effect of suicide prevention centres on suicide rates in the United States. Health Services Report. 37-39.Levenson, M.,

Lester, D. (1991). The study of suicidal lives. Suicide and Life Threatening Behaviour. 21, 2, p. 164-173.

Lester, D., Beck, A. T. & Mitchell, B. (1979). Extrapolation from attempted suicides to completed suicides: A test. Journal of Abnormal Psychology. 88, p. 78-80.

Liberman, R. P. & Eckman, T. (1981). Behaviour therapy versus insight - oriented therapy for repeated suicide attempters. Archives of General Psychiatry. 38, 1126-1130.

Lineham, M. M. (1986). Suicidal people. Annals New York Academy of Sciences. 17-33.

Lineham, M. M. (1987a). Dialectical behavioral therapy: A cognitive behavioral approach to parasuicide. Journal of Personality Disorders. 1, 4, 328-333.

Lineham, M. M. (1987b). Dialectical behaviour therapy for borderline personality disorder. Bulletin of the Menninger Clinic. 51, 3, 261-276.

Lundh, L. G. (1988). Cognitive therapy and the analysis of meaning structures. In C. Perris, I. Blackburn & H. Perris. Eds. Cognitive Psychotherapy. Heidelberg; Springer.

Luscomb, R. L., Clum, G. A. & Patsiokas, A. T. (1980). Mediating factors on the relationship between life stress and suicide attempting. Journal of Nervous and Mental Disease. 168, 644-650.

Madigan, R. & Bollenbach, A. No date. Reciprocal influences of thinking, moods, and behaviour in relation to depression and suicide. University of Alaska. Anchorage.

Mahoney, M. J. (1991). Human change processes: The scientific foundations of psychotherapy. Basic Books.

Maltsberger, J. T. (1991). The prevention of suicide in Adults. In A. A. Leenaars Ed. Life span perspectives of suicide. NY: Plenum.

Maltsberger, J. & Buie, D. H. (1974). Countertransference hate in the treatment of suicide. Archives of General Psychiatry. 30, 625-633.

Manton, K. G., Blazer, D. G. & Woodbury, M. A. (1987). Suicide in middle age and later life: Sex and race specific life table and cohort analyses. Journal of Gerontology. 42, 219-227.

Maris, R. W. (1981). Pathways to suicide. Baltimore, MD: John Hopkins University Press.

Maris, R., Berman, A. L., Maltsberger, J. T. & Yufit, R. I. (1992). Assessment and prediction of Suicide. NY: Guilford Press.

McConnaughy, E. A., DiClemente, C. C., Prochaska, J. O. & Velicer, W. F. (1989). Stages of change in psychotherapy. Psychotherapy. 26, 4, p. 494-503.

McIntosh, J. L. (1992). Epidemiology of suicide in the elderly. Suicide and Life Threatening Behaviour. 22, 15-35.

McIntosh, J. L. & Jewell, B. L. (1986). Sex different trends in completed suicide. Suicide and Life Threatening Behaviour. 16(1), p. 16-27.

Melges, F. T. & Weisz , A. E. (1971). The personal future and suicidal ideation. Journal of Nervous and Mental Disease. 153, 244-250.

Miller, D. H. (1967). Suicidal careers: Towards a symbolic interaction theory of suicide. Doctoral Dissertation. University of California, Berkeley, CA.

Miller, J. B. (1984). The development of women's sense of self. Stone Centre Working paper Series. Wellesley, MA: The Stone Centre.

Miller, J. (1980). Helping the suicidal client: Some aspects of assessment and treatment. Psychotherapy: Theory, Research & Practice. 17, 94-100.

Modestin, J. (1987). Counter-transference reactions contributing to completed suicide. British Journal of Medical Psychology. 60, p. 379-385.

Montgomery, S. A. & Montgomery, D. (1982). Pharmacological prevention of suicidal behaviour. Journal of Affective Disorders. 4, 291-298.

Moss, L.M. & Hamilton, D. M. (1956). The psychotherapy of the suicidal patient. American Journal of Psychiatry. 112, 814-820.

Motto, J. A. (1974). Refinement of variables in assessing suicide risk. In A.T. Beck, H.P.L. Resnick & D. J. Lettieri. Eds. The prediction of suicide. MD: Charles.

Motto, J. A. (1976). Suicide prevention for high risk persons who refuse treatment. Suicide and Life Threatening Behaviour. 6, 223-230.

Motto, J. A. (1991). An integrated approach to estimating suicide risk. Suicide and Life Threatening Behaviour. 21, 74-89.

Murphy, G. E. (1972). Clinical indication of suicidal risk. Archives of General Psychiatry. 27, 356-359.

Murphy, G. E., Armstrong, J. W. & Hermele, S. L. (1979). Suicide and alcoholism: Interpersonal loss confirmed as a predictor. Archives of General Psychiatry. 36, 65-69.

Murphy, G. E. & Wetzel, R. (1982). Family history of suicidal behaviour among suicide attempters. Journal of Nervous and Mental Disease. 170, p. 86-90.

Murray, D. C. (1972). The suicide threat: base rates and appropriate therapeutic strategy. Psychotherapy: Theory, Research & Practice. 9: 176-179.

Nelson, V. L., Nielson, E. C. & Checketts, K. T. (1977). Interpersonal attitudes of suicidal individuals. Psychological Reports. 40, 983-989.

Nelson, S. H. & Grunebaum, H. (1971). A follow-study of wrist slashers. American Journal of Psychiatry. 127, 10, 81-85.

Nickerson, E. T. (1977). Learned helplessness in women: Or how to be a woman without being depressed. Annual Meeting of The American Association of Suicidology 10th. Boston.

Nidiffer, D. F. (1980). Combining cognitive and behavioral approaches to suicidal depression: a 42 month follow up. Psychological Reports. 47, 539-542.

Neuringer, C. (1964). Rigid thinking in suicidal individuals. Journal of Consulting Psychology. 28, 54-58.

Neuringer, C. (1971). Problem-solving behaviour in suicidal adolescents. Journal of Consulting and Clinical Psychology. 37, 433-436.

Neuringer, C. & Lettieri, D. J. (1971). Cognition, attitude and affect in suicidal individuals. Life Threatening Behaviour. 1, 118-123.

Osborne, J. W. (1990). Some basic existential-phenomenological research methodology for counsellors. Canadian Journal of Counselling. 24:2, p. 79-91.

Page, M. M. (1972). Demand characteristics and the human operant conditioning experiment. Journal of Personality and Social Psychology. 23, p. 372-378.

Panksepp, J. (1993). Where, when, and how does an appraisal become and emotion? The times they are a changing. Psychological Inquiry. Vol.4. No.4.

Parloff, M. B. (1978). Research on therapist variables in relation to process and outcomes. In S. Garfield & A. Bergin, Handbook of psychotherapy and behaviour change. NY: John Wiley & Sons.

Patterson, C. H. (1984). Empathy, warmth, and genuineness in psychotherapy: a review of reviews. Psychotherapy, 2, 431-438.

Patsiokas, A. T. & Clum, G. A. (1985). Effects of psychotherapeutic strategies in the treatment of suicide attempters. Psychotherapy. 22, p. 281-290.

Patsiokas, A. T., Clum, G. A. & Luscomb, R. L. (1979). Cognitive characteristics of suicide attempters. Journal of Consulting and Clinical Psychology. 47, 478-484.

Paykel, E. S ., Hallowell, C., Shapiro, D. L. & Weissman, M.M. (1974). Treatment of suicide attempters: A descriptive study. Archives of General Psychiatry. 31, 487-491.

Paykel, E. S. (1976). Life stress, depression and attempted suicide. Journal of Human Stress. 2, 3, 3-12.

Paykel, E. S. (1989). Stress and life events. In L. Davidson & M. Linnoila. Eds. Report to the secretary's task force on youth suicide: Risk factors for youth suicide. Washington, DC: U.S. Printing Office.

Perlmutter, R. A. & Jones, E. J. (1985). Problem solving with families in psychiatric emergencies. Psychiatric Quarterly. 57, 23-32.

Peterson, L. G. & Bongar, B. (1990). Training physicians in the clinical evaluation of the suicidal patient. In M. S. Hale (Ed.) Methods in teaching consultation-liaison psychiatry. Adv Psychosom Med. Basel, Karger. Vol. 20, p. 89-108.

Pokorny, A.D. (1966). A follow up of 618 suicidal patients. Archives of General Psychiatry. 40, 249-257.

Putnam, F. W. (1989). Diagnosis and treatment of multiple personality disorder. NY: Guilford Press.

Ramsay, R. F., Tanney, B., Tierney, R. & Lang, Wm. A. (1991). Suicide Prevention Training Program-Canadian Mental Health Assoc. AB.

Rice, L. (1974). The evocative function of the therapist. In D. Wexler & L. Rice. Eds. Innovations in client centred therapy. NY: Interscience.

Rich, A. R. & Bonner, R. L. (1988). Negative life stress, social problem solving, self appraisal and hopelessness. Unpublished manuscript, U.S. Penitentiary, Lewisburg. PA. (Cited in Maris et al., 1992. p.556.)

Ringel, E. (1973). The pre-suicidal syndrome. Psychiatria Fennica. 209-211.

Robins, E., Gassner, S. & Kayes, J. (1959). The communication of suicide intent. American Journal of Psychiatry. 115, 724-733.

Robins, E. (1985). Suicide. Comprehensive textbook of psychiatry. MD: Williams & Witkins.

Rogers, C. R. (1959). Client centred therapy. In S. Arieti (Ed.) American handbook of psychiatry. Vol.3. NY: Basic Books.

Rogers, C. R. (1961). On becoming a person. Boston: Houghton Mifflin.

Roy, A. (1982). Risk factors for suicide in psychiatric patients. Archives of General Psychiatry. 39, 1089-1095.

Rush, A. J. & Beck, A. T. (1978). Cognitive therapy of depression and suicide. American Journal of Psychotherapy. 32, 201, 219.

Rush, A. J., Beck, A. T., Kovacs, M., Weissenberger, J. & Hollon, S. (1982). Comparison of the effects of cognitive therapy and pharmacotherapy of hopelessness and self concept. American Journal of Psychiatry. 139, 862-866.

Rudestam, K. E. (1986). Suicide and the selfless patient. In J. Travers & E. Stern. Eds. Psychotherapy and the selfless patient. Haworth Press.

Ryckman, R. M. (1982). Theories of personality. CA: Brooks Cole.

Salkovskis, P., Atha, C. & Storer, D. (1990. Cognitive-behavioral problem solving in the treatment of patients who repeatedly attempt suicide. British Journal of Psychiatry. 1S7, 871-876.

Schotte, D. E. & Clum, G. A. (1987). Problem solving skills in suicidal psychiatric patients. Journal of Consulting and Clinical Psychology. 55, 49-54.

Schulsinger, F., Kety, S., Rosenthal, D. & Wender, P. (1979). A family study of suicide. In M. Schou & Stromgren. Eds. Origin, prevention and treatment of affective disorders. London: Academic Press.

Seligman, M. (1975). Helplessness: On depression, development and death. San Francisco: W. H. Freeman.

Shaffer, D., Garland, A., Gould, M., Fisher, P. & Trautman, P. (1988). Preventing teenage suicide: A critical review. Journal of the American Academy of Child and Adolescent Psychiatry. 27, 6, 675-687.

Shainess, N. (1976). Treatment of crisis in the lives of women: Object loss and identity threat. American Journal of Psychotherapy. 31, 2, 227-237.

Shapiro, K. J. (1986). Verification: Validity or understanding. Journal of Phenomenological Psychology. 23, 167-179.

Shapiro, P. (1985). An analysis of suicide. Suicide and Life Threatening Behaviour. 15, 2, 124-129.

Shneidman, E. S. (1985). Definition of suicide. NY: Wiley.

Shneidman, E. S. (1987). A psychological approach to suicide. In G. R. Vanden Bos & B. K. Bryant. Eds. Crises, cataclysms, and catastrophes. Washington D.C.: American Psychological Association.

Shneidman, E. S. (1992). A conspectus of the suicidal scenario. In R. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit. Eds. Assessment and prediction of suicide. NY: Guilford Press.

Singer, M. (1977). The experience of emptiness in narcissistic and borderline states: The struggle for a sense of self and the potential for suicide. International Review of Psychoanalysis. 4, 471-479.

Smith, M. L., Glass, G. V. & Miller. (1980). The benefits of psychotherapy. MD: John Hopkins University Press.

Sorensen, S. B. & Rutter, C. M. (1991). Transgenerational patterns of suicide attempts. Journal of Consulting and Clinical Psychology. 59, 861-866.

Stengel, E. (1964). Suicide and attempted suicide.

Harmondsworth:Penguin.

Swenson, E. V. (1986). Legal liability for a patient's suicide. The Journal of Psychiatry & Law. 14, 3. p. 409-433.

Szasz, T. S. (1971). The ethics of suicide. The Theology of Medicine. NY: Harper.

Szasz, T. S. (1989). A moral view on suicide. Suicide: Understanding and responding. Connecticut: International Universities Press.

Tuckman, J. & Youngman, W. F. (1968). A scale for assessing suicide risk for attempted suicides. Journal of Clinical Psychology. 24, 17-19.

Watzlawick, P., Weakland, J. & Fisch, R. (1974). Change: Principles of problem formation and problem resolution. NY: Norton.

Weaver, D. B. & Smith, M. A. (1986). Interaction map approach to suicide prevention. 19th Annual Meeting of the American Association of Suicidology. 262-264. Atlanta.

Weishaar, M. E. & Beck, A. T. (1990). Cognitive approaches to understanding and treating suicidal behaviour. In S. J. Blumenthal & D. J. Kupfer. Eds. Suicide over the life cycle. Washington, DC: American Psychiatric Press.

Weissman, M. M. (1979). Psychological treatment of depression: Evidence of the efficacy of psychotherapy alone, in comparison with, and in combination with pharmacotherapy. Archives of General Psychiatry. 36, 1261-1269.

Weissman, M., Beck, A. T. & Kovacs, M. (1979). Drug abuse, hopelessness, and suicidal behaviour. International Journal of Addictions. 14, p. 451-464.

Weissman, M.M., Fox, K. & Klerman, G. L. (1973). Hostility and depression associated with suicide attempts. American Journal of Psychiatry. 130, 450-455.

Weiner, M. B. & White, M. T. (1982). Depression as the search for the lost self. Psychotherapy, Theory, Research and practice. 19, 4, 491-499.

Welu, T. (1977). A follow-up program for suicide attempters: Evaluation of effectiveness. Suicide and Life Threatening Behaviour. 7, 17-30.

Wertz, F. J. (1984). Procedures in phenomenological research and the question of validity. In C. M. Aanstoos. Ed. Exploring the lived world. West Georgia College Studies in the Social Sciences. 23, 29-43.

Wetzel, R. D. (1976). Hopelessness, depression and suicidal intent. Archives of General Psychiatry. 33, 1069-1073.

Whitaker, C. L. & Slimak, R. E. (1990). College student suicide. Journal of College Student Psychotherapy. 4, 3/4.

Wilkins, W. (1979). Expectancies on therapy research: Discriminating among heterogeneous non specifics. Journal of Consulting and Clinical Psychology. 47, 5, P. 837-845.

Wubbolding, R. E. (1987). Professional ethics: Handling suicidal threats in the counselling session. Journal of Reality Therapy. 7, 1. p.12-15.

Yufit, R. I. (1977). Suicide, bereavement and time perspective. In B. L. Danto & A. H. Kutscher. Eds. Suicide and Bereavement. NY: Arno.

APPENDIX

SUICIDAL HEALING RESEARCH PROJECT

Project Purpose

Different perspectives of suicidal behaviour are offered by the theorist, therapist or observer. Each contribute to the understanding and treatment of suicidal behaviour. This study proposes to acquire a view from an additional perspective; the view of persons who were once suicidal.

Project Benefits

Personal stories of healing will contribute to the understanding and treatment of suicidal behaviour, providing benefit to others. For those interviewed, it is an opportunity to contribute to that outcome, and to explore their own process of healing.

Project Tasks

The major task is telling a personal life story. Several contacts are involved: initial contact, a personal interview, a review of the pooled descriptions, and a session to present the final project.

Project Inconveniences and Risks

The expected inconvenience is one of time, for each contact and overall. It is expected to take several months to complete the interviews, analyze the data and present the final project.

A possible risk is discomfort in remembering and describing prior suicidal experience. Rather than discomfort, this process may be experienced as clarifying one's own process and solidifying the gains in the personal process of healing. Should discomfort occur, this will be discussed and referrals made as necessary.

Project Participants

Two groups will be involved in the project: the researchers and the interview participants. Participants will be adult men and women who have experienced suicidal feelings and behaviour, who have had no attempts for at least two years, and wish to share and explore their experience of healing. Each participant will be asked for a signed consent of participation and release of information. Participants may also withdraw at any time. To do so simply requires notifying the principal researcher of the wish to withdraw from further participation.

Confidentiality of Personal Information

Confidentiality and anonymity will be maintained by altering names and any unique information. The original interview data will be available only to the researchers, secured during the project, and destroyed following completion of the project. The final project will constitute a doctoral thesis to be housed in the university library.

SUICIDAL HEALING RESEARCH PROJECT

PROCEDURAL GUIDELINES

# 1. Screening

Respondents will be thanked for their interest, and asked what further information they require to consent to participate in the project. Questions will be answered about the nature, purpose and process of the project.

Respondents will be asked what kinds of suicidal behaviour they have engaged in, if they have had repeated suicidal crisis, when they last engaged in suicidal behaviour, and what they would like to gain from this experience.

If respondents meet the criterion, and are willing to participate, an interview date will be set.

# 2. Exploration of Healing

Participants will be given the written description, the project will be discussed and written consent obtained.

The interview will be begin with an introduction like:

Our coming together to talk is through your response to the invitation to talk about the healing process from suicide, and your experience of what was helpful for you.

Between thinking, feeling and acting on suicidal impulses and the recognition that you were no longer suicidal is a process of healing. This is the area I would like to focus upon: How did you get from thinking, feeling and acting suicidal to being suicidal no longer? What made the difference between wanting to die, acting on it, and wanting to live?

Perhaps the easiest way is to follow the path you took, what happened with all its turns; the people, events, thoughts and feelings along the way from being suicidal to being suicidal no longer. Can you trace this path? Will you start with when you were suicidal and go from there?

As participants describe WHAT happened, prompts will be made to elucidate HOW things came about and the nature of impact. Questions, stimulated from the review of the literature, may be asked at the end of the interview, if comment has not been made of those areas.

# 3. **Feedback and Discussion of Final Project**

The interview significant statements will be analyzed and the thematic structure will be written up, and presented to the participants for their impressions and feedback. They will be asked if the thematic structure makes sense to them and represents their experience.

ADVERTISEMENT

SUICIDAL NO LONGER !

SUICIDAL HEALING RESEARCH PROJECT

Have you been suicidal?
Are You 18 + years old?
And free of suicidal behaviour for 2 years?

Would you:
. participate in a confidential interview,
. share your story of healing,
. explore your experience,
. contribute to the understanding of suicidal healing?

Contact:
Suicidal Healing Research Project
Weekday Hours 9-5

482 -0198

Interviews are confidential, with a Chartered Psychologist
Research to be documented as Doctoral Thesis, University of Alberta.
Research applied to assist healing the suicidal.

SUICIDAL HEALING RESEARCH PROJECT

INFORMED CONSENT

Research Project:	Suicidal Healing Research Project Dept. of Ed. Psychology, Counselling University of Alberta
Principal Researcher:	Muriel Hoover
Supervising Committee:	Dr. P. Sartoris Dr. B. Paulson Dr. J. Osborne

I have read the description and discussed the research project.

I have an understanding of:

i) the purpose and nature of the project,
ii) the expected benefits,
iii) the tasks involved,
iv) the inconveniences and risks,
v) the identity of those involved in the project,
vi) who will receive the information,
vii) how the information will be used,
viii) the right to give or withhold consent for participation,
ix) the right to withdraw at any time during the process,
x) how confidentiality will be maintained.

I give my informed consent to participate in the project.

....
Date

....
Name of Participant

....
Name of Researcher

SUICIDAL HEALING RESEARCH PROJECT

RELEASE OF INFORMATION

Research Project:	Suicidal Healing Research Project Dept. of Ed. Psychology, Counselling University of Alberta
Principal Researcher:	Muriel Hoover
Supervising Committee:	Dr. P. Sartoris Dr. B. Paulson Dr. J. Osborne

I give permission to the principal researcher, **Muriel Hoover**, to release information obtained during personal interviews to the supervising committee, and, to use the information obtained, with confidentiality and anonymity maintained, for analysis and documentation in a doctoral dissertation at the University of Alberta.

....
Date

....
Name of Participant

....
Name of Researcher

SUICIDAL HEALING RESEARCH PROJECT

General Interview Guide

I. Being Suicidal

1. Experience a suicidal crisis? One or more? When?

2. What happening in life?

3. What did you do?

4. What want to achieve?

5. What response: others? self?

II. Following Suicidal Behaviour

1. What happened next?

   As describe WHAT, inquire HOW come about? Impact?

   Possible dimensions:

   Events, situations, activities, communications

2. Who involved, supportive, and not?

3. What changed in your external world?

4. What changed inside, or for you?

   Body/Health, Feelings, Thoughts/Beliefs, Behaviours

5. Significant Pivotal Points?

6. What made the difference between living and dying?

7. What made the difference in resolving the life issue?

8. How recognize no longer suicidal?

9. What stops you from engaging in suicidal behaviour now?

10. What do now, if were to feel suicidal again?

(To all the whats, How did it happen, and make a difference?)

Table 7

EXAMPLE PHENOMENOLOGICAL PROTOCOL ANALYSIS

Illustration of Phases of Individual Participant Protocol Analysis

	SIGNIFICANT STATEMENT	PSYCHOLOGICAL PARAPHRASE	THEME
# 4	PARTICIPANT		
401	It first started when I was eleven, which was kind of young I guess. And then it went, the last one I remember was when I was fifteen and a half, about fifteen and I attempted three or four times within that, but I thought of it constantly, it was kind of a constant thing in my life. And I still think about it occasionally, but it is not an option for me, it is different thinking about it now.	Suicidal ideation started at age 11 and she thought abut it constantly, attempting several times. No longer thinks of suicide as an acceptable option.	Constant ideation. Several attempts. Suicide no longer an option. Thinks of suicide differently.
402	I never fit in at school. I was a really homely, I was the homeliest kid and that was hard for me because I got teased all the time, and things like that and I have a sister, just one sister, and my mom treated her very much differently, she was really close to my sister and it was really obvious that, every one noticed that she treated my sister so much better than me, and that was a hard thing for me to deal with, it was really hard.	Considered herself homely, was teased at school, treated differently than her sister by mother, felt left out.It was hard dealing with the way she was treated.	Negative self judgements. Teased. Treated differently. Felt left out by Mother. Never felt fit in.

Table 7

EXAMPLE PHENOMENOLOGICAL PROTOCOL ANALYSIS

Illustration of Phases of Individual Participant Protocol Analysis

	SIGNIFICANT STATEMENT	PSYCHOLOGICAL PARAPHRASE	THEME
# 8	PARTICIPANT		
801	I saw a lot of abuse, I saw a lot of people yelling at each other, ... my brothers punching each other until the blood come out of their lips and their eyes would be black and I would get picked on because of my size, ... parents fighting... the yelling stuff and withdrawing from each other, walking away in a rage. And, I remember that I always wanted out. I did not want to be in that environment.	Witnesses and experiences abuse and violence. Wanted out of environment.	Experienced violence, physical abuse. Wanted out of environment.
802	I stayed really distant from it. Really distant.	Protected himself from violent situation by remaining distant.	Protected self, distanced.
805	I never did the action. I've held knives in my hand ready to cut my wrists. We had a big pine tree, I'm from Newbrunswick, and we had a big pine tree on our land and I'd been in that tree ready to jump out... I was eleven.	Didn't act to suicide, was poised with knives to cut and in the tree ready to jump.	Rehearsed suicidal behaviour.
808	We used to kill cats and we'd put them on the end of an exhaust pipe and I never could get the keys, but I'd thought of that. That was another avenue that I was going to take because we put them in burlap bags, fertilizer bags and put them on the exhaust pipe, and they'd just meow once and then they'd die peacefully. I thought that would be a nice way to go.	Thought a nice way to die would be to do it like they used to kill cats: in a bag connected to the car exhaust.	Collected suicide options.

Table 8

Themes: A Journey Away and Return to Self

	Second Order Themes	First Order Themes
	AWAY FROM SELF	
I.	Context: Learning What is Lived	1. Loss 2. Negative Interaction 3. Invalidation
II.	Coping: Living What is Learned	1. Silencing 2. Withdrawal, Dissociation 3. Constriction 4. Accepting Responsibility
III.	Worthlessness	5. Acting Out
IV.	Awareness of Suicidality	1. Function 2. Recognition
V.	Deterrents to Suicidality	
VI.	Suicidal Behaviour	
	RETURN TO SELF	
VII.	Crisis	
VIII.	Reaching Out: Connecting With Others	1. Connecting 2. Experiencing Support 3. Misconnections
IX.	Reaching In: Connecting With Self	1. Opening to Feelings 2. Connecting Feelings 3. Connecting Suicidality 4. Identifying Fears 5. Unfinished Business 6. Articulating Anger 7. Struggling With Denial
X.	Breaking Patterns	1. Listening to Self 2. Using Awareness 3. Maintaining Connections 4. Determining Needs, Boundaries 5. Expressing Self 6. Receiving Feedback
XI.	Evaluating	1. Responsibility 2. Impact of Experience, Treatment 3. Selecting, Acting on Goals
XII.	New Patterns: Honoring Self	1. Self Accepting 2. Self Advancing 3. Self Enduring

Table 9

PHENOMENOLOGICAL THEMATIC ANALYSIS

Journey Away and Return to Self

	First & Second Order Themes	Generalized Description
	Journey Away From Self	
I.	Context: Learning What Lived	
	1. Loss	Loss and disrupted attachments with significant others; through death, divorce, emotional or physical separation; loss of health and functioning, goals; loss of structure, direction, sense of a personal future.
	2. Negative Interaction	Physical abuse, sexual abuse, emotional abuse: criticism, blaming, judgement, disapproval, denial, discounting; stress and conflict in parenting and relationships.
	3. Invalidation	Invalidation through messages, alliances, distorted beliefs, power struggles, the experience of not belonging, being treated differently, being unloved, blamed, not supported or protected, being publicly humiliated, punished; having one's sexuality challenged.
II.	Coping: Living What Learned	
	1. Silencing	Suppressed, denied feelings or reactions; inability to disclose events, feelings or reactions; make, and/or refuse requests, demands.
	2. Withdrawal, Dissociation	Emotional, physical, social isolation: into self, from others, activities and/or self: numbing, unreality, being 'out of self'.
	3. Constriction	Regulated, blocked awareness: of self, others or information; limited or expanded focus, contact and/or activities; being regulated, blocked by others.
	4. Accepting Responsibility	Protected self, others from abuse; accepted punishment to protect others, accepted blame, punished self; resolved to do it better.
	5. Acting Out	Redirected, misdirected, projected responsibility: through anger, an 'attitude', violence towards self, others, animals; with physical problems; or addictions: activity, eating, alcohol, drugs, sexual behaviour.
III.	Worthlessness	Felt judgement, experience of not belonging, feeling unimportant, unloved, unlovable, shamed by those from whom wanted love and approval; felt inadequate, unable to cope; blamed and rejected self for 'being', hurting, and/or becoming what they hated; believed God rejected.

IV.	Awareness of Suicidality	
	1. Function	To die/and or not to die, to be out of environment, escape; to have someone know their pain; to release or unburden others, to be reunited in death.
	2. Recognition	Aware distressing demands, situations, memories, feelings triggered death, escape thoughts and behaviours; recognized life crisis: crisis of worth, feeling, responsibility, not suicidal crisis; suicidal thoughts beyond control, without choice; impulsive; shocked by recognition of suicidality.
V.	Deterrents to Suicidality	Religion, children, not knowing how, requiring the perfect plan, intervention, interruption, dissociation; anger, winning the power struggle; perseverance to resist ideation, control actions; impact of suicide bereavement; insight, altered perspective.
VI.	Suicidal Behaviour	Childhood, teen, adult thoughts of death; wished to die, prayed to die; ideation, perseveration with thoughts of suicide; wagering, high risk behaviour; collected plans, rehearsed, attempted, repeated attempts.
	Return to Self	
VII.	Crisis	Automatic impulse to survive; life went on, simply continued; crisis stimulated search: to make the best of living, to find help, solutions; internal shifts: did not have to die, can choose, re-decide.
VIII.	Reaching Out: Connecting With Others	
	1. Connecting	Reached out, disclosed, established emotional connections.
	2. Experiencing Support	Discovered not alone; became involved, shared feelings, problems; experienced support when others respected experience, listened, encouraged, understood, drew limits, held accountable; when experienced enough safety to risk, explore and confront issues; drew support, comfort from pets, nature, passages, activities.
	3. Misconnections	Sought help, counselling and unable to establish connection: difficulties, self dismissed, felt patronized, invisible, not heard, understood, blamed, treated perfunctorily, inappropriately; within a context of caring felt emotional void.
IX.	Reaching In: Connecting With Self	
	1. Opening to Feelings	Discovered need to feel; acknowledged, identified, accepted feeling; distinguished between feeling and action; struggled with fear of feeling, feelings.

2. Connecting Feelings	
a. Experiencing Feelings	Feelings, issues, impact revealed through experiential exercises, life encounters, massage. To feel brought incredible pain.
b. Making Connections	Recognized current feelings, thoughts, behaviour, reactions connected to patterns: comfort of chaos and crisis, lack of boundaries, silent expectations, inability to communicate needs, requests; unmet expectations; unhealthy defenses block meeting needs, help, resolve; self punishment, physical pain distracts.
3. Connecting Suicidality	Recognized memories and events had associated feelings triggering suicidal thoughts and behaviour.
4. Identifying Fears	Identified fears born out of context and coping with losses, negative interaction, invalidation, feelings of worthlessness: fear of abandonment, closeness/rejection, becoming powerless and losing control through need to be loved, when things go wrong, when inadequate, exposed; fear of future violence, loss, illness.
5. Unfinished Business	Clarified unfinished business: being heard and understood; unmet needs, expectations and requests; need to clear emotional baggage.
6. Articulating Anger	Articulated the anger towards others for abusing, not protecting; towards self for impulsivity, lack of self trust; towards professionals for denying experience, treating as if invisible and incompetent; the stigma of depression, suicidality; towards God for abandoning, not allowing death, taking away something loved.
7. Struggling With Denial	Struggle with denial, to self and others: of feelings, behaviour, dealing with painful history.
X. Breaking Patterns	
1. Listening to Self	Acknowledges, goes with feeling, takes time to process; respects need for safety.
2. Using awareness	Utilizes awareness of patterns and feelings to focus, direct self care, resolve issues; developing awareness of own process and how to process feelings.
3. Maintaining Connections	Stays present, connected and open to self, others, activities and information; confronts silence and denial; breaks silence, secrets, reveals self; practices emotional honesty.
4. Determining Needs, Boundaries	Distinguishes self, needs, choices from others'; refuses choices made by others or to accept abuse.
5. Expressing Self	Expresses feelings, needs, boundaries; refuses, requests, negotiates, explores, confronts, expresses appreciation; expresses directly, owning rather than blaming.

	6. Receiving Feedback	Experiences validation when feelings, experience supported; when feels valued, attended to, believed in, rather than judged, criticized.
II.	Evaluating	
	1. Responsibility	Evaluates responsibility for behaviour as belonging to self or others: rejects false blame, responsibility; accepts responsibility for self, feelings, behaviour, actions.
	2. Impact of Experience, Treatment	Evaluates impact of behaviour, experience, treatment: rejected what not helpful, not understanding or inconsistent with experience, knowledge and self awareness; maintains what helpful when feels better or experiences physical changes, response changes, suicidal urges cease, feel enjoyment and emotional connection. Without direction pursues old patterns.
	3. Selecting, Acting on Goals	Pursues education, skills, employment, relationships, support, treatment, information; changes behaviour, environments; engages in self care, self help and practises strategies.
III.	New Patterns: Honouring Self	
	1. Perspectives on Self: Self Accepting	The place of pain was not loving the self, caring for others' over self; shifted focus from others approval, discovered attending to self was permissable, a right to set boundaries, express, protect, pursue own needs; engaged in self reflection, focused on self care, provided self with love, nurturing; appreciated self and others, aware of worth and identity; accepted struggle to appreciate self, to become own person.
	2. Perspectives for Living: Self Advancing	Discovered they could act on their own behalf, their own truth: broke silence, disclosed, communicated, developed awareness of self, others; discovered could feel safe, didn't have to withdraw, could withstand fear, invalidation; valued connections, began to accept own and others'limits; found enjoyment, friends, activities, accomplishments, own choices, limits, purpose.
	3. Perspectives on Healing: Self Enduring	Healing began with self care, focus on feelings; suicidality didn't change until started to feel, deal with the feelings; suicide was only the outer layer, healing was doing little things one at a time, with treatments, helpers focusing differently. Healing was 'distilling stored tainted emotions'. Realized could manage difficulties, feelings without suicidal action, could choose, re-decide to live; and endure.